Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 7/2/2020 12:14:57 PM
To: Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
Subject: RE: a few notes on this weeks spreadsheets

Good morning. We are connected.

From: Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>
Sent: Thursday, July 2, 2020 7:41 AM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Subject: FW: a few notes on this weeks spreadsheets

Ex. 5 Deliberative Process (DP)

Jennifer Orme-Zavaleta, PhD
Principal Deputy Assistant Administrator for Science
Office of Research and Development
US Environmental Protection Agency

DC 202-564-6620
Cell Ex. 6 Personal Privacy (PP)

From: Baxter, Lisa <Baxter.Lisa@epa.gov>
Sent: Thursday, July 2, 2020 7:09 AM
To: Baynes, Jeremy <baynes.jeremy@epa.gov>; Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>; Cascio, Wayne <Cascio.Wayne@epa.gov>
Cc: Bell, Matthew <Bell.Matthew@epa.gov>
Subject: a few notes on this weeks spreadsheets

Notes

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Lisa

From: Baynes, Jeremy <baynes.jeremy@epa.gov>
Sent: Thursday, July 02, 2020 12:25 AM
To: Baxter, Lisa <Baxter.Lisa@epa.gov>; Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>; Cascio, Wayne <Cascio.Wayne@epa.gov>
Cc: Bell, Matthew <Bell.Matthew@epa.gov>
Subject: RE: Hope it's not as late a night this week!

See attached.

JB

From: Baxter, Lisa <Baxter.Lisa@epa.gov>
Sent: Wednesday, July 1, 2020 10:23 PM
To: Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>; Baynes, Jeremy <baynes.jeremy@epa.gov>; Cascio, Wayne <Cascio.Wayne@epa.gov>
Subject: RE: Hope it's not as late a night this week!

Hi Jennifer,

Ex. 5 Deliberative Process (DP)

Lisa

From: Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>
Sent: Wednesday, July 01, 2020 9:39 PM
To: Baynes, Jeremy <baynes.jeremy@epa.gov>; Baxter, Lisa <Baxter.Lisa@epa.gov>; Cascio, Wayne <Cascio.Wayne@epa.gov>
Subject: Hope it's not as late a night this week!

Jennifer Orme-Zavaleta, PhD
Principal Deputy Assistant Administrator
Office of Research and Development
US EPA
Office 202-564-6620
Cell. Ex. 6 Personal Privacy (PP)
Sent from my iPhone

Message

From: Shaw, Betsy [Shaw.Betsy@epa.gov]
Sent: 6/25/2020 9:28:34 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
CC: Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]
Subject: FW: Office Operations Update
Attachments: NVFEL dash 6-25-20 all criteria.pdf; NVFEL dash 6-25-20 criteria II.pdf

FYI. Notice sent in Ann Arbor. I hope this week's process of reopening decisions was less stressful for you all than the previous rounds.

Thanks,

Betsy

From: Cook, Leila <cook.leila@epa.gov>
Sent: Thursday, June 25, 2020 5:20 PM
To: Shaw, Betsy <Shaw.Betsy@epa.gov>
Cc: Dunham, Sarah <Dunham.Sarah@epa.gov>; Monroe, Scott <Monroe.Scott@epa.gov>
Subject: FW: Office Operations Update

For your files and for Larry if you chose. If you'd like me to send to Larry or would Mark B.? be appropriate I am happy to do that just let me know. I have also shared with Region 5 and OECA folks.

From: Cook, Leila
Sent: Thursday, June 25, 2020 5:15 PM
To: OAR-OTAQ (AA) Everyone <OAROTAQ_AA_Everyone@epa.gov>; R5 and CID Ann Arbor Calendar Access <R5-and-CID-Ann-Arbor@epa.gov>; AA Non OTAQ EPA Employees <AA-Non-OTAQ-EPA-Employees@epa.gov>
Cc: Hengst, Benjamin <Hengst.Benjamin@epa.gov>; Simon, Karl <Simon.Karl@epa.gov>; Haley, Mike <Haley.Mike@epa.gov>; Dunham, Sarah <Dunham.Sarah@epa.gov>
Subject: Office Operations Update

Colleagues,

Administrator Wheeler has emphasized that our plan for a phased return to our workplaces is both measured and deliberate to minimize risk to your health. Our plan provides for a "rolling reopening," so each facility will proceed through the phases after a thorough review of health information that comprises the gating criteria outlined in the Opening Up America Again Guidance, while keeping in mind any city, state, or county requirements as well.

During the review of 14-day trend data this week for the National Vehicle and Fuel Emissions Laboratory (NVFEL) campus in Ann Arbor, Michigan, our Agency experts determined that the gating criteria to enter Phase 1 were not met and are in fact now trending upwards. Please see the attached charts demonstrating this trend upward. Because of this, the Administrator decided that we should extend our closure period until next week when we will decide if we should move into Phase 1. While we are considering other data and the posture of state and local governments when making phasing decisions, in this case we believed it was warranted to delay moving to Phase 1.

The NVFEL campus remains closed to ensure that any possible virus in those facilities is rendered inactive prior to employees' return. Any spaces that need to be accessed during the extended closure will be cleaned and disinfected before entering Phase 1. We will be following our own guidance on cleaning and disinfecting, which we developed with the Centers for Disease Control and Prevention (CDC), throughout this process. Please have your Division Director contact Ruth Schenk and me should access to a facility during the extended closure be needed. Access must be approved in advance.

Your health and safety are our top priority, and we will continue to keep you updated on the status of our locations.

Thank you and be well,

Lee Cook

EPA Facility Status Dashboard

About | Home | Criteria I | Criteria II | Criteria III

Last updated: **06/24/2020**

For questions about this dashboard.

EPA Facilities

- Facility is not meeting all criteria
- Facility is meeting all criteria over the previous 7 days
- Facility is meeting all criteria over

Region 5- OCSPP - Lab - Fort Meade MD
701 Mapes Road
Fort Meade, MD 20755-5350

MI
Region 5 - Field Office - Flint MI
1300 Bluff Street
Flint, MI 48504-0000

MI
OAR - Field Office - Ann Arbor MI
2000 Traverwood Drive
Ann Arbor, MI 48105-2195

MI
Region 5 - Field Office - Traverse

Criteria I

Downward trajectory of influenza and COVID-like illness (ILI / CLI) symptoms within 14-day period

Goal I-a: Number of reported weekly new

Goal I-a
Statewide ILI Symptoms are trending down or there is minimal ILI activity

tbd

Criteria II

Documented COVID-19 cases and prevalence of positive tests must trend downward for 14 days (while not decreasing the overall number of tests

Goal II-a: Number of reported daily new cases in the commuting area trends down

Goal II-a
New COVID-19 cases are not trending down over the previous 14 days

tbd

Incidence over last 14 days
33.9
cases per 100,000 people

Criteria III

Local hospitals must have the capacity to treat all patients without crisis care and jurisdictions must have a robust healthcare worker testing program and plan in place

Goal III-a
ICU Capacity Remaining
39.6%

Goal III-b
Percent of COVID-19 tests that are positive
7.9%

https://experience.arcgis.com/experience/d0c8f22f35bb459f87f25d88c3b2f2bc/page/page_2/

EPA Facility Status Dashboard

About | Home | Criteria I | Criteria II | Criteria III

Last updated: 06/24/2020

EPA Facilities

● COVID-19 cases are not trending down

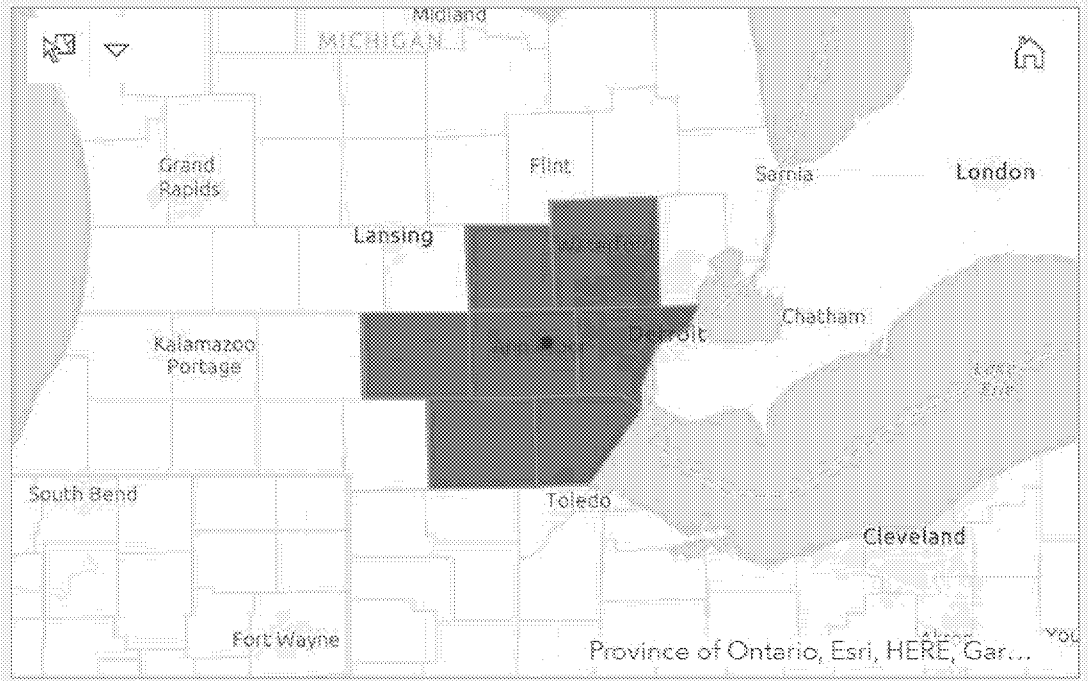
COVID-19 cases are trending down over the previous 7 days

MI
Region 5 - Field Office - Flint MI
1300 Bluff Street
Flint, MI 48504-0000

MI
OAR - Field Office - Ann Arbor MI
2000 Traverwood Drive
Ann Arbor, MI 48105-2195

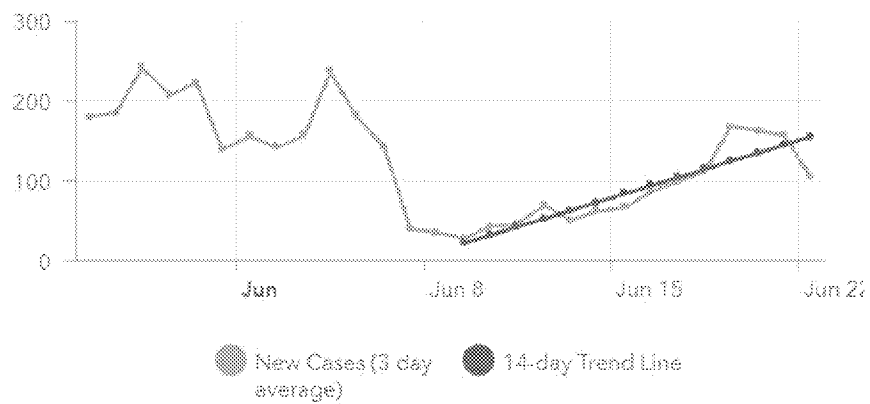
MI
Region 5 - Field Office - Traverse City MI
806 Hastings Street
Traverse City, MI 49686-0000

MN



Criteria II

Daily New Covid-19 Cases (previous 28 days)



See About Tab for how trend was determined

Population	Confirmed COVID-19	COVID-19 Incidence Rate
3,978,953	37,477	33.9 cases per 100,000 people

14 Day Trend

New COVID-19 cases are trending up over the previous 14 days

Goal: Downward trend for 14

14 Day Trend

This trend is statistically significant

p-value = 0.0000

Message

From: Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]
Sent: 6/29/2020 11:27:31 AM
To: Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Vizian, Donna [Vizian.Donna@epa.gov]
Subject: FW: Follow-up to Conversation with Wayne Cascio (ORD)
Attachments: CDC-Activities-Initiatives-for-COVID-19-Response.pdf; NAS COVID Public Health Data.pdf; People Who Are at Higher Risk for Severe Illness _ Coronavirus _ COVID-19 _ CDC.pdf

Thinking this might be good to put on the Agency site too, what do you think?

Jennifer Orme-Zavaleta, PhD
Principal Deputy Assistant Administrator for Science
Office of Research and Development
US Environmental Protection Agency

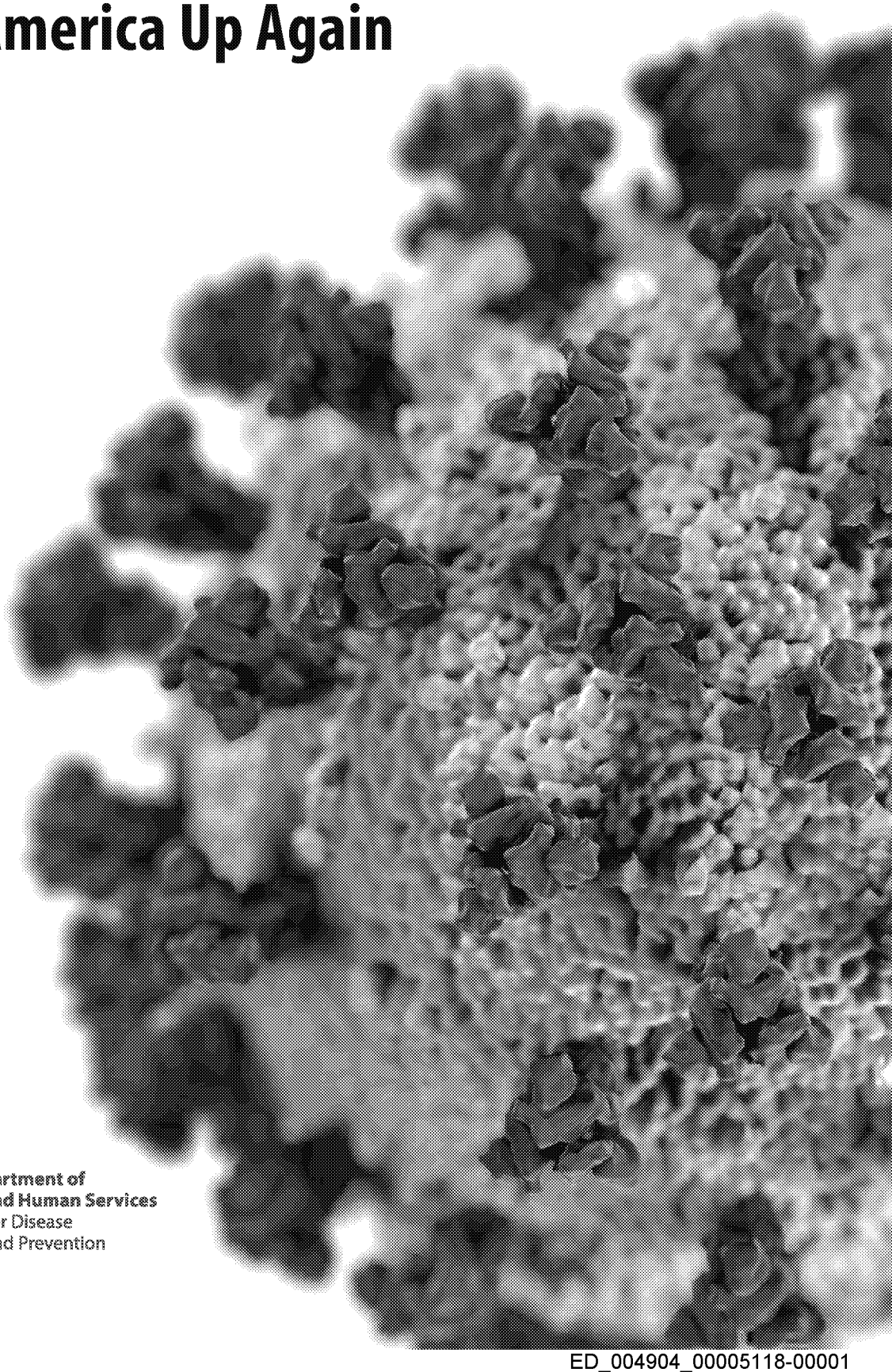
DC 202-564-6620
Cell Ex. 6 Personal Privacy (PP)

From: Cascio, Wayne <Cascio.Wayne@epa.gov>
Sent: Sunday, June 28, 2020 1:28 PM
To: Thomas, Deb <thomas.debrah@epa.gov>
Cc: Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>
Subject: Follow-up to Conversation with Wayne Cascio (ORD)

Deb – Thanks for taking the time this morning by allowing me to answer your questions in more detail. Attached are two documents that can serve as reference material for consultation when questions come up. The CDC document (CDC-Activites-Initiatives-for-COVID-19-Response.pdf) provides an in depth description of the gating criteria, the data sources and interpretation. The NAS document (NAS COVID Public Health Data.pdf) provides an overview of the available public health data as well as the strengths and limitations of the data and cautions associated with interpretation. We continue to keep looking for such publications from reputable and credible sources to guide our data acquisition and analysis. The CDC document (People Who Are at Higher Risk for Severe Illness_Coronavirus_COVID-19.pdf) shows the most recent modification of the groups at higher risk from COVID-19 is also provided. Best wishes for a very enjoyable Sunday. Wayne

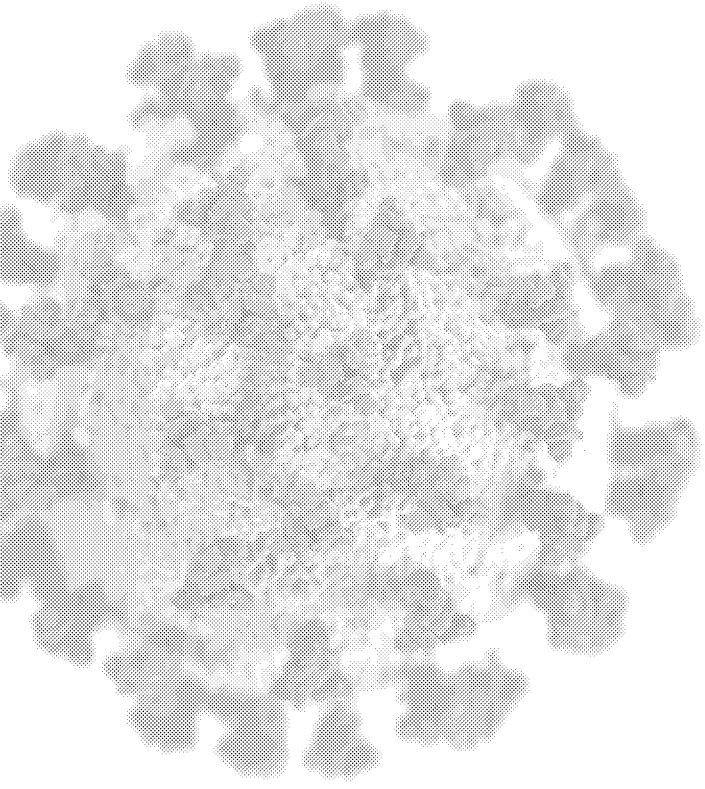
Wayne E. Cascio, MD, FACC | Director | Center for Public Health and Environmental Assessment | Office of Research and Development | U.S. Environmental Protection Agency | Research Triangle Park, NC 27711 | Phone: 919.541.2508 | Cell: 919.627.3762|

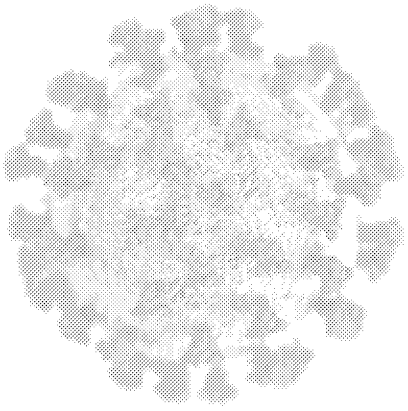
CDC Activities and Initiatives Supporting the COVID-19 Response and the President's Plan for Opening America Up Again

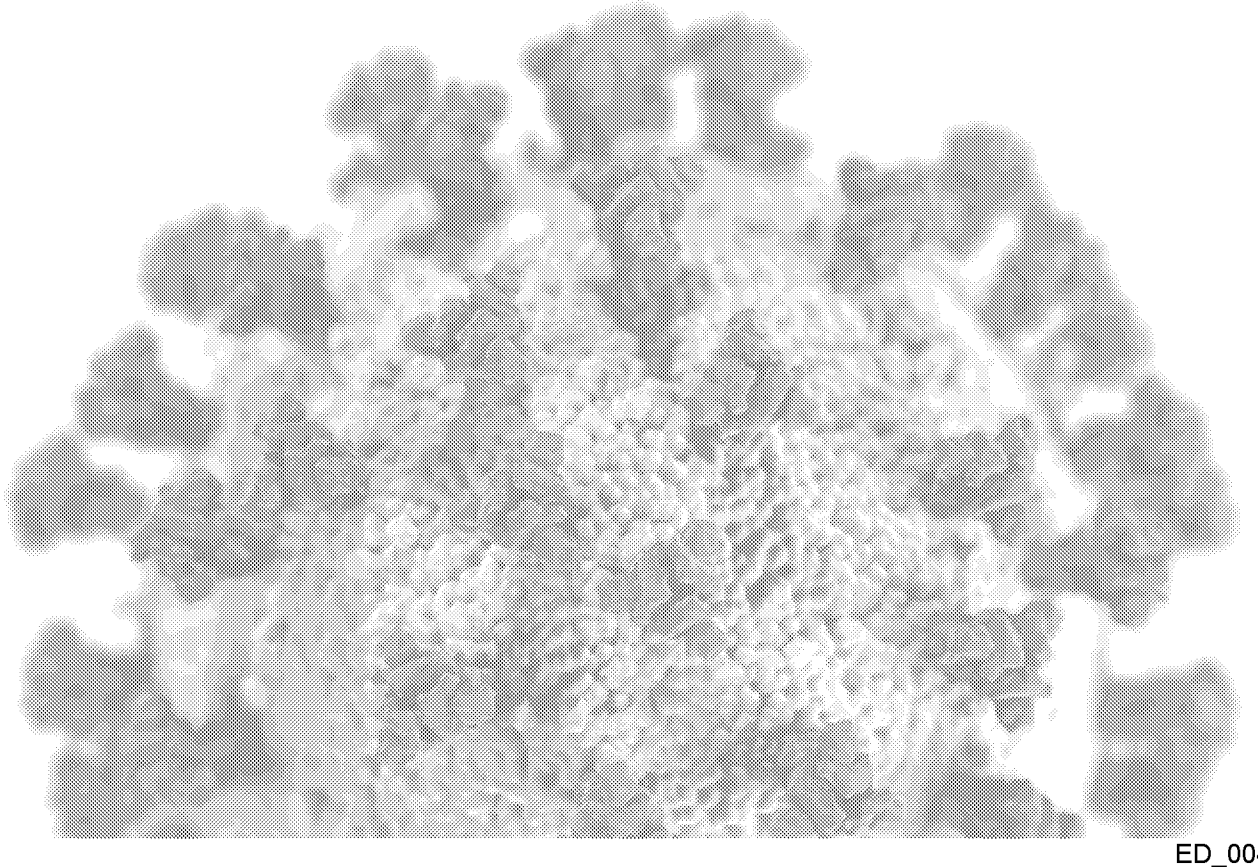


May 2020

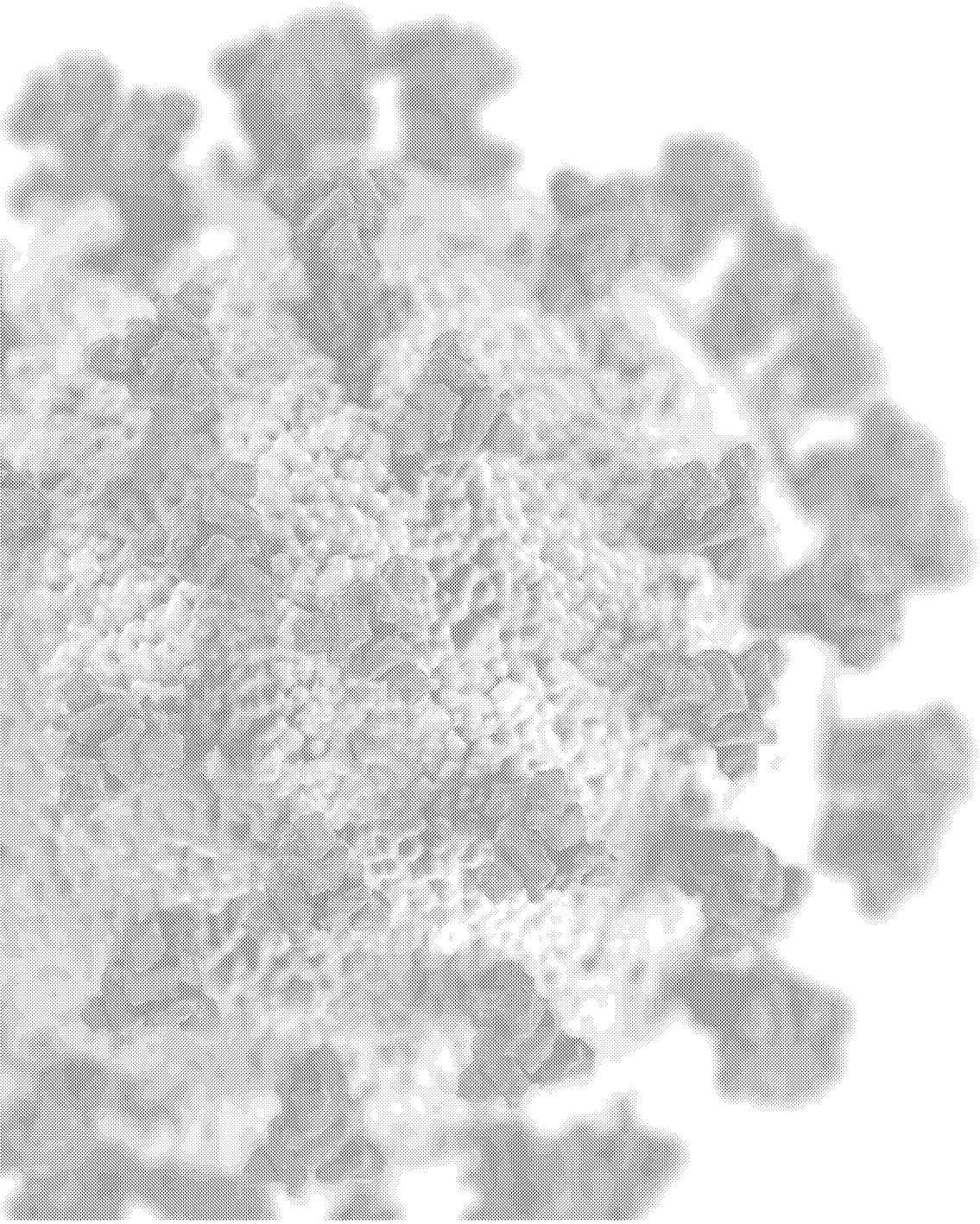
U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention







Contents



This document briefly summarizes CDC's initiatives, activities, and tools in support of the Whole-of-Government response to COVID-19.

Overview of CDC's Surveillance and Control Goals and Activities

The principal objectives of COVID-19 surveillance are to monitor the spread and intensity of the pandemic, to enable contact tracing to slow transmission, and to identify disease clusters requiring special intervention. Secondary objectives include understanding the severity and spectrum of disease, identifying risk factors for and methods of preventing infection, and producing data essential for forecasting. In addition to tracking the disease itself, monitoring of healthcare capacity and essential supplies through the National Healthcare Safety Network (NHSN) is critical to ensure adequacy of care.

Because no single system can capture all parameters of the pandemic, CDC has implemented multiple, complementary surveillance systems (Appendix A). Key systems are case-based reporting through the National Notifiable Diseases Surveillance System (NNDSS), laboratory-based surveillance, syndromic-surveillance data reported through the National Syndromic Surveillance Program (NSSP), and data on healthcare system capacity reported through the NHSN (Appendix B). Additional systems, such as COVID-Net, provide rich, publicly available information for meeting secondary objectives. CDC continues to explore emerging and experimental surveillance platforms with a critical eye toward proven utility.

Control of the epidemic requires action at the individual, community, and population levels. CDC has provided state, tribal, local, and territorial health departments with extensive detailed guidance on contact tracing, infection control, and a wide range of other prevention and control topics. Recent models suggest that asymptomatic and pre-symptomatic transmission and delays in case recognition can greatly reduce the effectiveness of contact tracing. To enhance the speed and thus effectiveness of contact tracing, CDC is exploring technologic methods for instantaneous voluntary notification of contacts of confirmed cases.

At the community level, recent events have shown the devastating effects that outbreaks can have among vulnerable populations, especially those in congregate settings such as nursing homes, prisons, and homeless shelters. Similarly, outbreaks in food production plants and other critical industries are crippling communities financially and threatening national food security. Rapid identification and response to these events is a CDC priority that can mitigate the immediate impact and provide critical insights needed to prevent future outbreaks in similar settings. CDC has developed extensive tools to assist states, counties, facilities, and industries in responding to and preventing these events (Appendix C).

Laboratory testing of asymptomatic individuals is an evolving consideration as more is learned about the role of asymptomatic and subclinical infections in transmission SARS-COV-2. Emerging evidence suggests that asymptomatic infections may play an important role in the epidemiology of the disease. However, it is important to define the circumstances where testing asymptomatic persons is likely to be helpful in controlling the COVID-19 pandemic. Interim guidance about laboratory test usage for asymptomatic populations and for serologic testing and serologic surveillance is provided in Appendix D.

Surveillance and hospitalization indicators can aid public health and government officials in their decisions when to reopen communities. The disease occurrence and hospital gating indicators in the Opening Up America Again guideline provide states and communities insight into the trajectory of the COVID-19 pandemic in their jurisdiction. These indicators are part of the broad assessment jurisdictions should undertake when deciding when and how to adjust community mitigation strategies for COVID-19 (Appendix E).

As businesses and other organizations gradually open after the COVID-19-related slowdown, they will need to consider a variety of measures for keeping people safe. These considerations include practices for scaling up operations, safety actions (e.g., cleaning and disinfection, social distancing), monitoring possible reemergence of illness, and maintaining health operations. Interim guidance for helping establishments with these steps is provided in Appendix F.

Widespread community mitigation combined with ongoing containment activities represents both an effective intervention for limiting the spread of COVID-19 and a serious threat to the economic well-being of the country and the world.

CRITICAL INITIATIVES AND ACTIVITIES

A. Expanding Testing and Advising Testing Practices

Extensive, rapid, and widely available COVID-19 testing is essential. CDC is working within the "All-of-Government and All-of-America Approach" to increase testing capacity and availability to improve case detection and contact tracing though all phases of the US plan to Opening Up America Again. As the supply and nature of tests expand, testing criteria have been broadened to include a wider range of people and situations.

Prioritizing Patients for Testing: Current recommendations for testing: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

Focusing Testing Efforts: CDC is working across the US government to support diverse efforts to increase testing in multiple settings to support diagnosis, surveillance, and outbreak control:

- **Testing for Diagnosis and Clinical Management:** CDC is working with federal government partners to support hospitals, healthcare systems, clinics, and public health departments to ensure the capability to diagnose COVID-19 infections with a turnaround time needed for appropriate clinical care and public health decision-making. CDC is:
  - » Working with federal government partners to provide a wide range of technical assistance resources to each state to help them develop a state-specific testing plan that meets their unique needs.
  - » Equipping state public health laboratories with sufficient quantities of devices, reagents, and testing supplies in the International Reagent Resource (IRR).
  - » Working with the White House Coronavirus Task Force to enhance the national supply of reagents and testing supplies so that the commercial market is able to supply state efforts. This supply should be sufficient to achieve a rate of less than 10% positive tests for COVID-19 among symptomatic, asymptomatic, and pre-symptomatic individuals.
- **Testing for Surveillance and Outbreak Control:** Identify newly emergent cases or clusters of COVID-19 among symptomatic and asymptomatic individuals who are prioritized by public health officials and clinicians, and improve reporting of COVID-19 cases to public health systems. CDC is:
  - » Utilizing established, nationwide surveillance systems to identify any areas of potential COVID-19 outbreaks, including use of CDC's Influenza-Like Illness Network and the National Syndromic Surveillance Program.
  - » Enabling public health systems at state, local, territorial, and tribal levels to develop a robust system to identify COVID-19 infections, particularly among vulnerable populations such as residents of nursing homes, people of racial and ethnic minority groups (e.g., African Americans, American Indians, Alaska Natives) at higher risk of disease, and those in areas of high social vulnerability, closed settings, and congregate housing.
  - » Supporting existing case-based surveillance efforts for identifying infections through routine testing of persons in clinical encounters.
  - » Enhancing case investigation and contact tracing efforts through increased public health staff and rapid testing capability.
  - » Working with point-of-care diagnostic test manufacturers and state health departments to improve reporting of results from rapid, point-of-care devices
  - » Evaluating various serologic assays for use in surveillance and for potential use for returning to work.

Defining Usage: CDC is working with state, local, and other partners to define the circumstances where testing of asymptomatic persons is likely to be helpful in controlling the pandemic, as well as the best application of surveillance serologic testing.

- Emerging evidence suggests that asymptomatic infections play an important role in the epidemiology of SAR-CoV-2 infections. Testing for asymptomatic infection should focus (1) on persons with an increased likelihood of infection and (2) on settings with particularly vulnerable populations.
- CDC is working to identify indications for serologic testing. Broadly, the purpose of serologic test falls into two categories: serologic surveillance of populations and serologic testing of individuals to determine if they have had a prior infection. This current CDC COVID-19 test is not currently designed for individual use (i.e., to test people who want to know if they have been previously infected with SARS-CoV-2). Serologic surveillance has the potential to provide important insights into the transmission dynamics of disease, as well as a more complete picture of total burden of COVID-19 infections in a community or among first responders and front-line health providers. More information is needed to determine how the results of serologic testing correlate with possible immunity.
- See Appendix D and https://www.cdc.gov/coronavirus/2019-ncov/lab/serology-testing.html for additional details on testing strategies, testing of asymptomatic infections, and serologic testing.

Augmenting Existing Infrastructure and Technology to Improve Data Flow and Reporting:

CDC is supporting the improvement of current data infrastructure, and the development and integration of digital/technology solutions to augment state and community-wide sites to ensure timely and transparent communication to all citizens inclusive of daily new cases, hospitalizations, use of intensive care units (ICU), and mortality by county and or zip code. To ensure geographic relevant information is continuously available to state and local governments and the public in those communities, this should also include laboratory and potential immunization data systems. Activities include:

- Working with state and local officials and web development groups to develop and support interactive web-based platforms that allow open and transparent data visibility to all communities, such as the Florida Public Health COVID-19 website.
- Working with manufacturers for point-of-care diagnostic tests, commercial laboratories, state and local health departments, testing locations (providers, hospitals, pharmacies), and public health partners (Association of Public Health Laboratories [APHL], Council of state and Territorial Epidemiologists [CSTE]) to improve data quality, integration, and electronic reporting.
- Developing, integrating, and testing the ability for laboratories to securely share data with digital platforms selected by public health, including platforms that may be used for testing, or to support state and local contract tracing.
- Exploring digital solutions to share laboratory results with patients directly and sharing tested best practices with state and local partners. This could also extend to immunization record access.
- Developing recommendations for minimum requirements of platforms to integrate, store, and manage personal laboratory information on digital platforms (what states should consider before investing or having additional standards for platforms handling these data).

B. Phased Plan and Indicators for Reopening America

The plan for reopening America outlines a three-phased approach for reducing community mitigation measures while protecting vulnerable populations. The phased approach can be implemented statewide or community-by-community at governors' discretion. The guidelines propose the use of six "gating" indicators to assess when to move through from one mitigation phase to another.

Table 1. Gating Criteria and Phase-specific Thresholds

Gating Criteria	Threshold for entering Phase 1	Threshold for entering Phase 2	Threshold for entering Phase 3
Decreases in newly identified COVID-19 cases	Downward trajectory (or near-zero incidence) of documented cases over a 14-day period	Downward trajectory (or near-zero incidence) of documented cases for at least 14 days *after entering Phase 1*	Downward trajectory (or near-zero incidence) of documented cases for at least 14 days *after entering Phase* 2
Decreases in emergency department (ED) and/or outpatient visits for COVID-like illness (CLI)	Downward trajectory (or near-zero incidence) of CLI syndromic cases reported over a 14-day period	Downward trajectory (or near-zero incidence) of CLI syndromic cases reported for at least 14 days *after entering Phase 1*	Downward trajectory (or near-zero incidence) of CLI syndromic cases reported for at least an additional 14 days *after entering Phase 2*
Decreases in ED and/ or outpatient visits for influenza-like illness (ILI)	Downward trajectory (or near-zero incidence) of ILI reported over a 14-day period	Downward trajectory (or near-zero incidence) of ILI reported for at least 14 days *after entering Phase 1*	Downward trajectory (or near-zero incidence) of ILI reported for at least an additional 14 days *after entering Phase 2*
Decreases in percentage of SARS-CoV-2 tests positive	Downward trajectory (or near-zero percent positive) of positive tests as a percentage of total tests over a 14-day period (flat or increasing volume of tests)	Downward trajectory (or near-zero percent positive) of positive tests as a percentage of total tests for 14 days *after entering Phase 1* (flat or increasing volume of tests)	Downward trajectory (or near-zero percent positive) of positive tests as a percentage of total tests for at least 14 days *after entering Phase 2* (flat or increasing volume of tests)
Treat all patients without crisis care	Jurisdiction inpatient & ICU beds <80% full Staff shortage in last week = no PPE supplies adequate for >4 days	Jurisdiction inpatient & ICU beds <75% full Staff shortage in last week = no PPE supplies adequate for >4 days	Jurisdiction inpatient & ICU beds <70% full Staff shortage in last week = no PPE supplies adequate for >15 days
Robust testing program	Test availability such that percentage of positive tests is ≤20% for 14 days Median time from test order to result is ≤4 days	Test availability such that percentage of positive tests is ≤15% for 14 days Median time from test order to result is ≤3 days	Test availability such that the percentage of positive tests is ≤10% for 14 days Median time from test order to result is ≤2 days

Decisions to move between phases should also consider the public health capacity of the jurisdiction based on the criteria listed below. Other epidemiologic data sources available locally can be used to corroborate trends seen in core epidemiologic gating criteria. Special consideration should be given to infections identified in populations and settings such as healthcare personnel, patients in healthcare facilities (e.g., nursing homes, dialysis centers, long-term care facilities), and residents of congregate living settings (e.g., prisons, youth homes, shelters), underserved populations, and people of racial and ethnic minority groups (e.g., African Americans, American Indians, Alaska Natives) at higher risk of disease. Incidence and trajectory (increasing versus decreasing) of COVID-19 illnesses in the surrounding region should also be considered.

Table 2. Assessing Capacity for Case Identification, Follow Up, and Containment

Category	Considerations for Assessing Capacity for Case Identification, Follow Up, and Containment
SARS-CoV-2 testing in jurisdiction	Testing is available as indicated for clinical, public health, and infection prevention needs.
Identification of new COVID-19 cases	All new COVID-19 cases in the jurisdiction can be rapidly identified through active surveillance, including proactive monitoring for asymptomatic cases through surveillance monitoring.
Interviewing new COVID-19 cases	Initial interviews can be conducted for nearly all new COVID-19 cases within one day of health department notification.
Contact tracing	Follow up (isolation, self-monitoring, and rapid testing of selected contacts) can be initiated for nearly all identified contacts of newly identified cases.
Incidence relative to local public health resources	Public health capacity is sufficient to fully perform contact tracing and investigate outbreaks based on local incidence and resources available.

While some communities will progress sequentially through the reopening phases, there is the possibility of recrudescence in some areas. Given the potential for a rebound in the number of cases or level of community transmission, a low threshold for reinstating more stringent mitigation standards will be essential. The decision to reinstate community mitigation strategies will undoubtedly be very difficult and will require careful thought to define an evidence-based monitoring strategy and specific guidance for these decisions.

Technical Support for States

As part of the "Whole-of-Government" public health effort, CDC is providing states and other jurisdictions with technical assistance regarding testing, surveillance data collection and reporting, contact tracing, infection control, and outbreak investigation. Implementation of these activities is supported by the Paycheck Protection Program and Health Care Enhancement Act, which includes $11 billion to be awarded, within 30 days, directly to states, localities, territories, tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes to develop, purchase, administer, process, and analyze COVID-19 tests, conduct surveillance, trace contacts, and related activities. Listed below are additional strategies CDC is using to strengthen the capacity of state, tribal, local, and territorial (STLT) health departments to fight against COVID-19. This technical assistance is essential to ready the nation to re-open and minimize future COVID-19 outbreaks in jurisdictions across the country.

Contact Tracing

Contact tracing, a core disease control measure used by local and state health department personnel for decades, is a key strategy for preventing further spread of infectious diseases, including COVID-19. Contact tracing is part of the process of supporting affected individuals and warning contacts of exposure in order to stop chains of transmission. CDC is ramping up America's capacity to perform contact tracing. As part of this effort, CDC has developed multiple training tools for communities to train the newest frontline workers in public health. CDC will train newly identified contact tracers on how to quickly locate and talk with the affected individuals, assist with isolation issues, and work with affected individuals to identify people with whom the affected individuals have been in close contact. Identification of contacts will allow further outreach by public health to identify individuals who need to self-isolate.

Table 3. CDC Priorities and Strategies to Support STLT Health Departments

Priorities	Strategies
Contact tracing guidance and training https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/index.html	Provide CDC guidance on case investigation and contact tracing to STLT health departments Address key issues such as staffing and roles, when to initiate an investigation, steps to the investigation, confidentiality and consent, self-isolation, quarantine, and necessary support services (housing, food, medicine); data management; digital contact tracing tools and technology; and evaluation and monitoring • Work with states to develop a comprehensive proactive plan for the identification of asymptomatic case in areas of high vulnerability and/or high rates of co-morbidities
Address surge staffing needs https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/response-corps.html	Use a multi-pronged approach to enhance and complement the efforts of STLT health department staff through innovative hiring mechanisms designed to address the surge staffing needs of STLT health departments. Provide access to a variety of mechanism to complement local efforts to increase capacity. • Realign existing CDC field staff • Deploy CDC teams to address outbreaks in special settings • Partner with CDC Foundation and other organizations to place surge staff for STLT health departments across the nation • Partner with other federal agencies (e.g., AmeriCorps) to offer staffing options with states • Facilitate access to a variety of contact tracing and case investigation training products and tools for a diverse and evolving public health workforce

Continued on the next page ▶

Priorities	Strategies
Innovative technologies	Support implementation of innovative methods and technologies at the STLT levels to help inform and guide the national response. • Develop guidance for assisting states and locals in evaluating tools, refining guidance, and identifying gaps in contact tracing workflow • Leverage partnerships to facilitate information sharing among our state and local partners regarding digital contact tracing tools • Share the landscape of digital tools, including those for contact tracing, case management, workforce management, and proximity tracking

Conclusion

As part of the Whole-of-Government Response, CDC has developed and is continually evaluating and improving the comprehensive surveillance program to generate essential data for tracking the pandemic and guiding the overall response to COVID-19. In addition, CDC is working with federal, state, and local partners to improve testing and to advise and support communities during the phased reopening of America.

Appendix A: Surveillance for COVID-19

The goals of US surveillance are to produce timely and accurate information at national, state, local and community levels to inform decisions on public measures for implementing and adjusting disease reduction strategies, to guide clinical decisions, to educate the public and key stakeholders, and to provide data for estimating and forecasting disease burden.

Surveillance Objectives

- To identify both symptomatic and asymptomatic/presymptomatic cases and track contacts to slow transmission of COVID-19 in the United States
- To monitor spread and intensity of COVID-19 disease in the United States
- To understand disease severity and spectrum of illness
- To understand risk factors for severe disease and transmission
- To monitor for virus changes
- To estimate disease burden
- To produce data for forecasting spread and impact
- To identify when thresholds have been met to adjust community mitigation measures

Approach

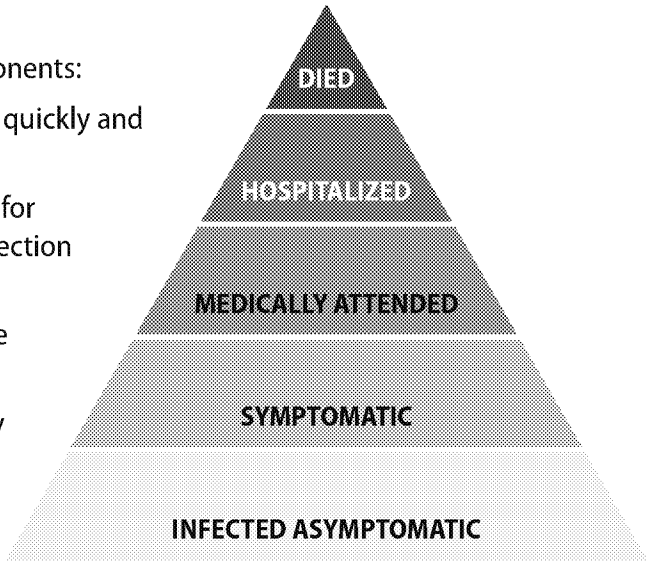
Using multiple surveillance systems and epidemiology networks, CDC in collaboration with state, local, and academic partners, monitors the progression and impact of COVID-19 spread in the United States. The combination of data from the different systems is used to generate an ongoing picture of virus spread and produce data to address the key questions for directing and refining the US response. Surveillance data are used for:

- *Situational awareness*—Timely monitoring of the spread and intensity of COVID-19 disease in the United States. Surveillance systems allow for efficient targeting of public health measures, developing timely communications, and preparing health systems for increasing numbers of ill people. Data from these systems will be updated daily or weekly to create an ongoing, accurate understanding of impacted regions, affected populations, trends over time, and viral characteristics.
- *Understanding impact and forecasting disease spread*—All surveillance systems will be employed to produce data to understand overall impact and epidemic characteristics to inform future use of public health and medical resources.
- *Characterizing COVID-19 infection* across a spectrum of conditions include:
  - » asymptomatic infections
  - » symptomatic infection
  - » medically attended outpatient and ambulatory visits
  - » hospitalizations
  - » deaths

Operational Plan

The plan is operationalized according to the following components:

- Increase laboratory testing and reporting to detect cases quickly and reliably for timely public health action
- Use robust syndromic surveillance, proactive monitoring for asymptomatic cases in settings with people at risk for infection or with known vulnerabilities
- Use laboratory reporting systems to monitor local disease trends to identify if thresholds (gates) have been met
- Corroborate trends and risk assessment with high-quality data from sentinel surveillance and systems
- Monitor disease and outbreaks in healthcare, institutional, workplace and group settings



- Use data for estimation of disease burden over time and to aid disease and transmission forecasts

Federal, State, and Local roles

The surveillance strategies rely on collaboration at federal, state, and local levels. The federal government will work with the states to establish the data platforms used by states and local jurisdictions to monitor transmission, public health, and health system capacity and provide technical assistance and coordination of information sharing and decision making across jurisdictions. These data platforms will be public facing to maximize transparency and maximize information to communities at the most granular level. Using the federal data systems, states can share data and information and communicate with residents' decisions under consideration and clear guidance on adhering to mitigation levels. In addition to implementing federal programs, states can also coordinate resource allocation within their regions and across communities and monitor indicators closely to make decisive adjustments to mitigation measures. Finally, local governments are responsible for feeding data and information into state and federal data systems and adjoining communities.

Components of the US COVID-19 surveillance plan

The surveillance program is built on a combination of existing influenza and viral respiratory diseases surveillance systems, syndromic surveillance systems, case reporting systems, proactive monitoring for asymptomatic cases in areas of demonstrated vulnerabilities, commercial laboratory reporting, ongoing research platforms employed for the COVID-19 response, and new systems. The systems are summarized in Table 4 and a more fully described in Appendix A.

Table 4. Surveillance Systems Used by Objective.

Surveillance data for decision-making uses multiple systems and epidemiology networks. These approaches use laboratory submitted specimens, electronically transmitted data, and other sources to generate an ongoing picture of disease spread, intensity, and severity, and produce data to address the key questions for directing and refining the US response.

Goal addressed	Outcome	Platform
Trends in disease spread and intensity	No. of cases, by location, trends, demographics, underlying diseases, outcomes	COVID-19 case-based surveillance
	No. of lab-positives; % positive, by age groups, location, over time	Public Health Laboratories (PHLs)
		National Respiratory and Enteric Virus Surveillance System (NREVSS)
		Commercial labs
	Outpatient, syndromic—%ILI, trends in ILI by region, age group, concordance and discordance between surveillance data	ILInet
		National Syndromic Surveillance Program (NSSP)
	Outpatient—laboratory-confirmed, % positive, by location, by age group	Laboratory-confirmed outpatient (OP) surveillance
		US Flu Vaccine Effectiveness (VE) network (acute respiratory illness)
Severity/clinical spectrum	Hospitalizations rates, by age group, underlying condition	FluSurvnet—all ages
	Hospitalizations	New Vaccine Surveillance Network (NVSN)—pediatrics
Viral changes	Virus characterization, sequence changes	PHLs and CDC/DVD SPHERES
Risk factors for severe disease	Risk of severe disease given underlying illness, age	COVID-19 case-based surveillance
		US Flu VE network
		FluSurvnet—all ages
		NVSN—pediatrics
		Hospitalized Adult Influenza Vaccine Effectiveness Network (HAIVEN)
		Influenza ICU Vaccine Effectiveness Study
		Pediatric Intensive Care Influenza Network (PICFLU)
Disease burden	Overall number of persons affected by severity and age	All systems, plus additional special research studies
		Serologic surveys
Pandemic severity	Pandemic Influenza Severity Assessment (PISA)	Modeling based on epidemiological inputs

Continued on the next page ▸

Goal addressed	Outcome	Platform
Forecasting and modeling spread and impact	When will it peak, how many disease outcomes, how will it spread	Modelling work with broad coalition of modelers led by CDC, using data above
Transmissibility	Attack rates and risk factors for transmission	Field studies
		Flu Transmission Evaluation Study (FLuTES)
		Household Influenza Vaccine Effectiveness Study (HIVES)
Risk Factors for Severe disease	Risk of severe disease given underlying illness, age	Pandemic cohorts (community, households, healthcare workers, pregnant woman, long-term care facilities)
Disease Burden	Overall number of persons affected by severity and age	All systems, plus additional special research studies
		Serologic surveys
Pandemic Severity	PISA	Modeling based on Epi inputs
Forecasting and modeling spread and impact	When will it peak, how many disease outcomes, how will it spread	Modelling work with broad coalition of modelers led by CDC, using data above
Transmissibility	Attack rates and risk factors for transmission	Field studies
		FLuTES
		HIVE
		Pandemic cohorts (community, households, HCWs, pregnant woman, LTCFs)

Appendix B: Healthcare System Surveillance

Rationale and Objective

Measuring and reporting the impact of COVID-19 on the capacity of the US healthcare system—including both acute-care hospitals and long-term care facilities—is an essential public health function in the pandemic response and in plans for Opening Up America Again. To make critical decisions, all levels of government, including federal, regional, state, local, tribal, and territorial, and the healthcare system need detailed and timely information about the availability and shortages of key resources, including hospital beds, intensive care unit (ICU) beds, ventilators, personal protective equipment, and healthcare personnel shortages. Reporting needs to be comprehensive across all states.

Regional variations in disease burden place a premium on supporting a surveillance system that can provide standardized data that are timely, easy to interpret, and readily accessible for multiple end users at all geographic levels. Among the main objectives for a national healthcare surveillance system in the current crisis are providing timely and readily available metrics with which to monitor the pandemic's trajectory and progress toward Opening Up America Again. The key surveillance metrics available from NHSN are reported counts and a panel of additional summary statistics on hospitalized COVID-19 patients, hospital bed capacity, intensive care unit bed capacity, ventilatory capacity, supplies of personal protective equipment, and staffing shortages. These metrics, produced daily, serve as indicators that can drive decisions and actions at the national, state, county, tribal, territorial, and healthcare facility levels but needs to be expanded to be inclusive of all hospitals.

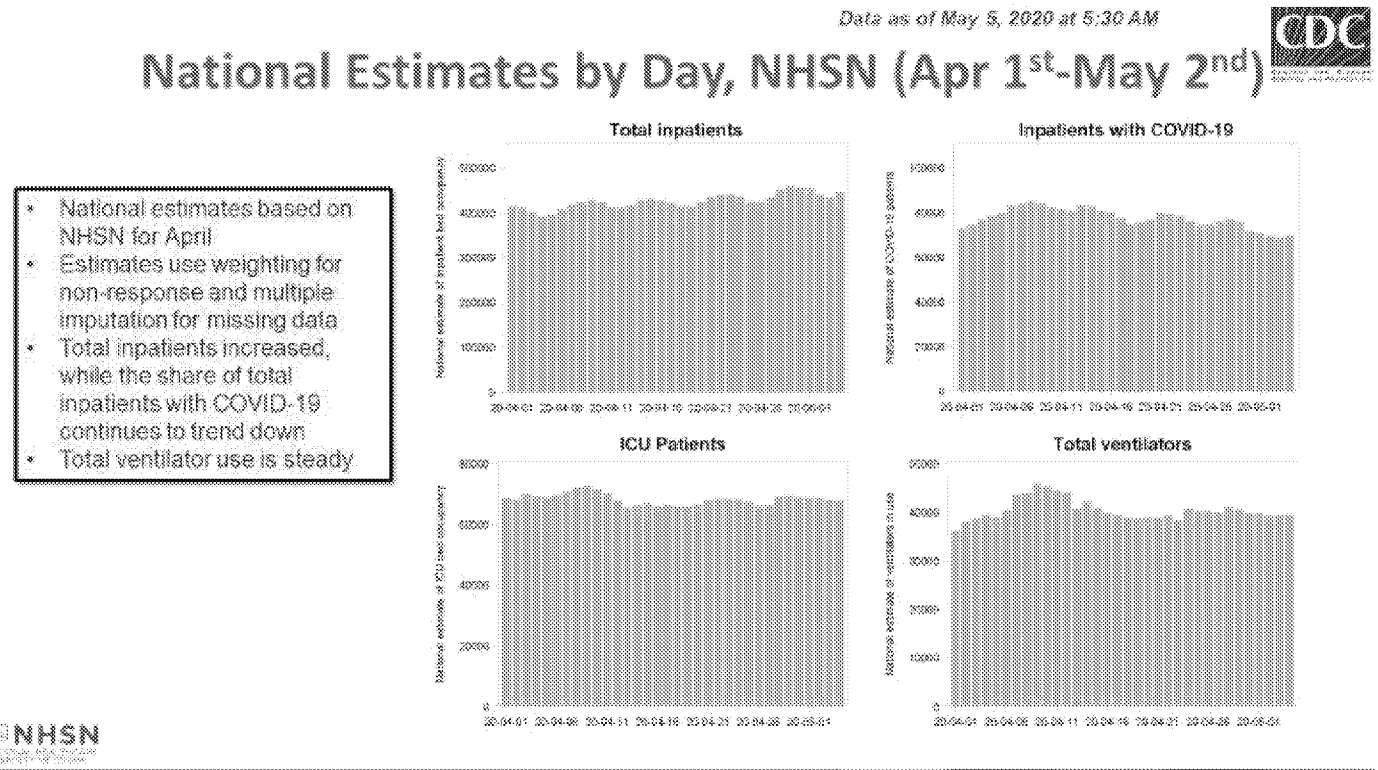
Key System

Implementation of several key surveillance metrics for monitoring the impact of the pandemic on the healthcare system are available through the existing Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN). NHSN's role as a shared platform for healthcare-associated condition surveillance provides a powerful and unique foundation for COVID-19 surveillance.

CDC is already efficiently leveraging NHSN—which was launched in 2005 and now is the nation's most widely used healthcare-associated condition tracking system—to support the nation's COVID-19 response. NHSN provides a well-established technical infrastructure, readily extensible platform, and a strong set of partnerships with healthcare facilities, state and local health departments, the Centers for Medicare and Medicaid Services (CMS), and electronic health record system (EHRs) companies, and other healthcare information technology suppliers. This system will need to continue improving to ensure 100% reporting of all cases and outcomes.

The US healthcare system relies on NHSN to track healthcare-associated conditions, improve patient safety, fulfill mandatory federal and state reporting requirements, and ultimately eliminate healthcare-associated conditions. NHSN serves as the operating system for hospital-associated infection reporting through legislation established by 36 states, Washington, D.C., and Philadelphia, PA. NHSN will need to be expanded to all states and all hospitals to provide a comprehensive analysis of COVID-19. CMS uses NHSN reporting to enable healthcare facilities to fulfill CMS requirements for submitting healthcare outcome data that are used in CMS's public reporting and incentive payment programs. Currently, over 25,000 healthcare facilities, including almost every hospital in the nation, more than 7,500 dialysis facilities, and over 3,000 nursing homes participate in NHSN. To be effective, this system must be nationwide and be comprehensive in reporting. Personnel in these facilities have extensive experience submitting data to NHSN, adhering to the system's surveillance protocols, and using their own data and national benchmarks provided by NHSN for local prevention and control purposes. NHSN's collaborations with EHR companies, infection surveillance system providers, and the Health Level Seven (HL7) data standards organizations enable healthcare facilities to submit data electronically to NHSN by using HL7 data exchange specifications.

On March 27, 2020, CDC launched the NHSN COVID-19 Patient Impact and Hospital Capacity Module (https://www.cdc.gov/nhsn/covid19/report-patient-impact.html), and as of April 24, 2020, over 56% of acute care hospitals and over 53% of critical access hospitals have reported COVID-19 surveillance metrics. This level of participation needs to continue to improve until reporting is at the 95–100% range. Additionally, as of April 28, 2020, all ~15,000 nursing homes will be required to report COVID-19 cases and deaths, as well as staffing and personal protective equipment supply metrics, to NHSN (https://www.cdc.gov/nhsn/ltc/covid19/index.html) per a new CMS Interim Final Rule. The adaptation of NHSN to the immediate needs of the emergency response is a clear example of how CDC is retooling, modernizing, and updating its existing national surveillance capabilities to confront the pandemic.

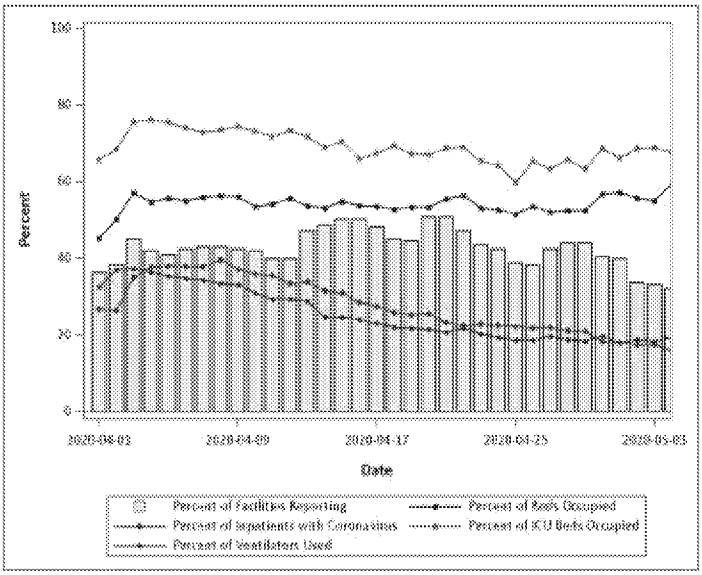


During the COVID-19 pandemic, data on key metrics are submitted daily to NHSN, where the data are analyzed daily and presented out to the key components at all levels of the public health response. NHSN COVID-19 data are an integrally important asset in the US government response. The NHSN data are provisioned for use in secure access systems maintained by the White House Coronavirus Task Force, the National Response Coordination Center (NRCC), CDC, FEMA, ASPR, and CMS. In addition, all state health departments, several local health departments, and many HHS ASPR and FEMA Regional Offices receive data from NHSN and rely upon it for regional and state emergency response decisions.

NHSN uses COVID-19 data to develop and report national and state-wide estimates that serve as indicators of stress on the healthcare system. Figures below show examples of national trend-data as well as an example of a state trend.

Data as of May 5, 2020 at 5:30 AM

NHSN Daily Crude Percent Occupancy, Louisiana



NHSN

Appendix C: Guidance on Infection Control and Contact Tracing

General CDC Guidance Hub https://www.cdc.gov/coronavirus/2019-ncov/communication/guidance-list.html?Sort=Date%3A%3Adesc

Infection Prevention Control

- **What CDC is doing for infection control**
  - » https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
- **Standard CDC guidance on infection control in healthcare settings**
  - » Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
- **Best practices currently in use by states and private sector**
- **Link to virtual training**
  - » Training for Healthcare Professionals (including clinical care and infection control, PPE, nonpharmaceutical interventions, emergency preparedness and response, and additional topics): https://www.cdc.gov/coronavirus/2019-ncov/hcp/training.html
  - » Preparing Nursing Homes and Assisted Living Facilities for COVID-19 (CDC webinar): https://www.youtube.com/watch?v=p1FiVFx5O78
- **Focus areas/congregate settings:**
  - » Long-term care facilities
    - › Preparing for COVID-19: Long-term Care Facilities, Nursing Homes: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html
  - » Assisted living facilities
    - › https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html
  - » Dialysis facilities
    - › https://www.cdc.gov/coronavirus/2019-ncov/hcp/dialysis.html
  - » Dental facilities
    - › https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html
  - » Ambulatory care facilities
    - › https://www.cdc.gov/coronavirus/2019-ncov/hcp/ambulatory-care-settings.html
  - » Pharmacies
    - › https://www.cdc.gov/coronavirus/2019-ncov/healthcare-resources/pharmacies.html
  - » Emergency Medical Services (EMS)
    - › https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html
  - » Food processing facilities
    - › Meat and Poultry Processing Workers and Employers: Interim Guidance from CDC and the Occupational Safety and Health Administration (OSHA)
    - › https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.html

- » Correctional facilities
  - › Resources for Correctional and Detention Facilities: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.
- » Businesses
  - › Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease 2019 (COVID-19): https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-business-response.html
  - › Prepare your Small Business and Employees for the Effects of COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-small-business.html

- **Other IPC tools/Resources:**
  - » IPC FAQs: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html
  - » Using PPE, including donning & doffing resources: https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html
  - » Healthcare preparedness tools: https://www.cdc.gov/coronavirus/2019-ncov/hcp/preparedness-checklists.html
  - » Strategies to mitigate staffing shortages: https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html
  - » Key strategies to prepare LTCFs: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html
    - › LTCF Letter to residents, family members and visitors: https://www.cdc.gov/coronavirus/2019-ncov/downloads/healthcare-facilities/Long-Term-Care-letter.pdf
  - » Cleaning and disinfecting school and community facilities: https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html
- **Cleaning and disinfecting non-emergency transport vehicles:** https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/disinfecting-transport-vehicles.html
- **External partners tools/resources**
  - » **Centers for Medicare & Medicaid—COVID partner toolkit**—https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit
  - » **American College of Emergency Physicians**—Field guide—https://www.acep.org/corona/covid-19-field-guide/cover-page/
  - » **American Academy of Pediatrics**—Guidance for Telehealth Payer Policy in Response to Covid-19 https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/aap-guidance-telehealth-payer-policy-in-response-to-covid-19/
  - » **Society for Critical Care Medicine**—COVID-19 Resource Center—Includes literature and training https://www.sccm.org/COVID19RapidResources/Home
  - » **Society for Healthcare Epidemiology of America**
    - › COVID-19 Resource Page: http://shea-online.org/index.php/practice-resources/priority-topics/emerging-pathogens/novel-coronavirus-2019-2019-ncov-resources
    - › Hospital epidemiology training—https://learningce.shea-online.org/content/sheacdc-outbreak-response-training-program-ortp#group-tabs-node-course-default1/index.php
    - › Rapid Response Program podcast and webinar series https://learningce.shea-online.org/content/novel-coronavirus-covid-19

- **Association for Professionals in Infection Control and Epidemiology**
  - COVID-19 Page: https://apic.org/covid19/
  - LTC text chapters: https://apic.org/resources/apic-text/apic-text-chapter-collection-long-term-care/
- **American Medical Association, Resource Center for Physicians**—https://www.ama-assn.org/delivering-care/public-health/covid-19-2019-novel-coronavirus-resource-center-physicians
- **American Nurses Association Resource Center**—https://www.nursingworld.org/practice-policy/work-environment/health-safety/disaster-preparedness/coronavirus/?utm_campaign=261605+COVID-19+MKT&utm_source=hero&utm_medium=digitalad&utm_content=covidresourcepage
- **American Dental Association**—COVID-19 Center—https://success.ada.org/en/practice-management/patients/infectious-diseases-2019-novel-coronavirus?utm_source=cpsorg&utm_medium=covid-nav&utm_content=nav-covid-19-center&utm_campaign=covid-19
- **Argentum (senior living)**—Toolkit—https://www.argentum.org/coronavirustoolkit/

- **Critical infrastructure workers**
  - Implementing Safety Practices for Critical Infrastructure Workers Who May Have Had Exposure to a Person with Suspected or Confirmed COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/critical-workers/implementing-safety-practices.html
  - Transportation and Delivery Workers:
    - https://www.cdc.gov/coronavirus/2019-ncov/community/transportation/index.html
  - Airport, Airline Workers
    - What Airline Customer Service Representatives and Gate Agents Need to Know about COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/airport-customer-factsheet.html
    - What Airport Baggage and Cargo Handlers Need to Know about COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/airport-baggage-cargo-handlers.html
    - What Airport Custodial Staff Need to Know about COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/airport-custodial-staff.html
    - What Airport Passenger Assistance Workers Need to Know about COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/airport-passenger-assistance-workers.html
    - What Aircraft Maintenance Workers Need to Know about COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/aircraft-maintenance-workers.html
  - Other transit workers:
    - What Bus Transit Operators Need to Know About COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/bus-transit-operator.html
    - What Rail Transit Operators Need to Know About COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/rail-transit-operator.html
    - What Transit Maintenance Workers Need to Know About COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/transit-maintenance-worker.html
    - What Transit Station Workers Need to Know About COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/transit-station-workers.html
  - Occupational Safety and Health Administration resources
    - Control and Prevention: https://www.osha.gov/SLTC/covid-19/controlprevention.html
  - Guidance on Preparing Workplaces for COVID-19: https://www.osha.gov/Publications/OSHA3990.pdf

- **Return to work**
  - » Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance): https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
- **PPE reuse guidance**
  - » Strategies to Optimize the Supply of PPE and Equipment (including eye protection, isolation gowns, facemasks, N95 respirators, elastomeric respirators, and ventilators): https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html
  - » Decontamination and Reuse of Filtering Facepiece Respirators: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html
  - » Personal Protective Equipment (PPE) Burn Rate Calculator: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html
- **Sustainable Isolation**
  - » Interim Infection Control Guidance for Public Health Personnel Evaluating Persons Under Investigation (PUIs) and Asymptomatic Close Contacts of Confirmed Cases at Their Home or Non-Home Residential Settings at https://www.cdc.gov/coronavirus/2019-ncov/php/guidance-evaluating-pui.html
  - » Public Health Guidance for Potential COVID-19 Exposure Associated with International Travel or Cruise Travel at https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html
  - » Public Health Recommendations for Community-Related Exposure at https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html
  - » Links to programs to support people in isolation: https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/index.html
  - » Links to housing support for people without safe places for isolation: https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/unsheltered-homelessness.html
  - » Links to federal programs- unemployment etc.
  - » www.coronavirus.gov
  - » https://www.coronavirus.gov/smallbusiness/
  - » https://www.irs.gov/coronavirus-tax-relief-and-economic-impact-payments
  - » https://www.usa.gov/unemployment
- **Call center for clinical inquiries 24/7 (770-488-7100)**
  - » https://www.cdc.gov/cdc-info/ask-cdc.html
- **Others**
  - » NIH COVID-19 Treatment Guidelines: https://www.covid19treatmentguidelines.nih.gov/overview/
  - » Therapeutic options: https://www.cdc.gov/coronavirus/2019-ncov/hcp/therapeutic-options.html
  - » Infectious Diseases Society of America Guidelines: https://www.idsociety.org/practice-guideline/covid-19-guideline-treatment-and-management/
  - » Information for Pediatric Healthcare Providers: https://www.cdc.gov/coronavirus/2019-ncov/hcp/pediatric-hcp.html
  - » Considerations for Inpatient Obstetric Healthcare Settings: https://www.cdc.gov/coronavirus/2019-ncov/hcp/inpatient-obstetric-healthcare-guidance.html
  - » Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for Coronavirus Disease 2019 (COVID-19): https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html

Contact Tracing

- **Contact Tracing Overview:** https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/contact-tracing.html
- **Principles of Contact Tracing: Part of a Multipronged Approach to Fight the COVID-19 Pandemic**: https://www.cdc.gov/coronavirus/2019-ncov/php/principles-contact-tracing.html (also see PDF booklet: https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/principles-contact-tracing-booklet.pdf)
- **Sample Contact Tracing Training Plan:** https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/contact-tracing-training-plan.pdf
- **Digital Contract Tracing Tools for COVID-19:** https://www.cdc.gov/coronavirus/2019-ncov/downloads/digital-contact-tracing.pdf
- **Preliminary Criteria for the Evaluation of Digital Contact Tracing Tools for COVID-19:** https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/prelim-eval-criteria-digital-contact-tracing.pdf
- **External partners tools/resources**
  - » **Association of State and Territorial Health Officials:** Making Contact: A Training for COVID-19 Contact Tracers Introductory Online Course: https://learn.astho.org/p/ContactTracer
  - » **Johns Hopkins Bloomberg School of Public Health Center for Health Security:** Review of Mobile Application Technology to Enhance Contact Tracing Capacity for COVID-19 https://www.centerforhealthsecurity.org/resources/COVID-19/COVID-19-fact-sheets/200408-contact-tracing-factsheet.pdf
  - » **National Association of County & City Health Officials:** Building COVID-19 Contact Tracing Capacity in Health Departments to Support Reopening American Society Safely: https://www.naccho.org/uploads/full-width-images/Contact-Tracing-Statement-4-16-2020.pdf

Appendix D: Guidance on Test Usage (Asymptomatic Populations and Serology)

Information on testing prioritization can be found here: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

Testing asymptomatic populations

Testing of asymptomatic individuals is a growing consideration as the role of asymptomatic and subclinical infections in transmission becomes more apparent. Emerging evidence suggests that asymptomatic infections may play an important role in the epidemiology of the disease. Nevertheless, it is important to define the circumstances where testing asymptomatic persons is likely to be helpful in controlling the COVID-19 pandemic. Effective testing programs will focus on (1) persons with an increased likelihood of infection and (2) settings with particularly vulnerable populations, including but not limited to the following:

- Contacts of known (symptomatic or asymptomatic) cases. This may include testing of contacts going back one to two weeks before the onset of symptoms, particularly contacts who work with vulnerable populations.
- Residents and staff of long-term care facilities. Periodic testing and sentinel surveillance in these settings may serve to detect outbreaks early in this setting, where devastating outbreaks are known to occur and to be associated with high rates of asymptomatic infection. CDC is updating guidance for surveillance in these settings https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html.
- Other healthcare facility workers and first responders. Healthcare facilities may consider testing staff periodically, starting with staff in high traffic, high risk areas such as emergency departments.

Serologic testing

Serologic testing currently has little role in the diagnosis of acute disease but is already playing an important role in the response to the pandemic. The uses of serologic testing fall into two broad categories: serologic surveillance of populations and serologic testing of individuals for proof-of-prior infection.

Serologic surveillance

https://www.cdc.gov/coronavirus/2019-ncov/covid-data/serology-surveillance/index.html

Serologic surveillance has the potential to provide a more complete picture of how much infection has occurred already in the United States. Case-based surveillance for anything with a wide spectrum of severity will always miss many cases, and its increasingly clear that a substantial proportion of SARS-CoV-2 infections are asymptomatic. To the degree that SARS-CoV-2 infection results in measurable antibodies, serologic testing will pick up any infection.

The purposes of serologic surveillance are the following:

- To provide a more complete estimate of the incidence of infection.
- To determine the proportion of the population that was previously infected.
- To better understand transmission.
- To evaluate the impact of community mitigation measures.

CDC has published its COVID-19 Serology Surveillance Strategy at https://www.cdc.gov/coronavirus/2019-ncov/covid-data/serology-surveillance/index.html

External serosurveys

- CDC will support state, tribal, local, and territorial health authorities to plan and implement serosurveys in their populations with known prior exposure. Serial antibody tests, initial and confirmatory, will be used in all field studies to ensure enhanced positive predictive values.

Serologic testing of individuals for proof-of-prior infection (immunity)

https://www.cdc.gov/coronavirus/2019-ncov/testing/serology-overview.html

While the lay public often mistakenly refers to this as "serologic surveillance", it is fundamentally different and is at its core a clinical activity designed to guide decisions about specific individuals by determining whether or not they are already immune to the infection. Serologic testing may play a role in a back-to-work strategy provided it can be shown that serologic testing can reliably infer immunity. This immunity may not need to be absolute: protection against severe infection may be enough even if immunity against reinfection isn't reliable or durable.

While there appears to be considerable public optimism that serologic testing will allow return to work without the need for PPE or other precautions, there are many unknowns at this early date that limit implementation of serology for this purpose:

- The correlates of immunity to SARS-CoV-2 are not known and there are few or no data to confirm that antibodies detected in serologic tests correlate with such immunity. Studies in the US military during the 1970s showed that reinfection with endemic coronaviruses occurred in the presence of low levels of antibodies. Nonetheless, most experts feel immunity from infection is likely at least in the short term.
- The performance characteristics of serologic assays are not yet known, although there is much work ongoing to define those characteristics. Typically, a well-performing single step serologic assay may be expected to have a specificity of 95% (sensitivity is a secondary concern here, although also important), which is likely not enough for this purpose, given the potential consequences of COVID-19. Combining two different tests will be critical for improving performance and should be part of any strategy to utilize serologic testing for "immunity" determinations.
- The current seroprevalence is likely to be highly variable. In New York City, for example, with one of the highest incidence rates in the country, a recent survey among customers of retail outlets found a seroprevalence of 22%. Preliminary data at CDC from remainder clinical specimens in the New York City area found about half that rate; in Western Washington, the preliminary rate was closer to 5%. This has two implications:
- At best, the use of serologic testing for a back-to-work strategy would likely benefit fewer than 10% of the population currently.
- In the setting of a relatively low seroprevalence, any serologic test would have to have excellent performance characteristics. If a test with 95% specificity were used in a population with a true seroprevalence of 5%, almost half all "positives" would be false-positive and not immune and therefore must include 2 serial tests to confirm all positive results.
- There is a need for high-level consensus on the role of serologic testing in a back-to-work policy. The stakes are high for such a policy, so that in addition to the scientific data, there is also a need to have political consensus on this issue. Consensus is also needed on a plan for how to provide documentation of that immunity, be it through federal- or state-based immunity registries, digital proof-of-immunity, or physical documentation such as "immunity certificates".

Despite these limitations, continued interest in the use of serologic testing in a back-to-work policy is likely. In the meantime, CDC is doing the following:

- Working with NIH/NCI, FDA, and ASPR on evaluating the first panel of 25 serologic assays. More testing will quickly follow these tests.
- Designing studies to track healthcare workers long term to monitor for evidence of reinfection.
- Tracking seroprevalence nationally, as described above.

Appendix E: Assessing Surveillance and Hospital Gating Indicators

This document is for use by public health and government officials to aid their decisions when to reopen communities. It describes four indicators specific to disease occurrence and hospital readiness, which form part of the "gating criteria" described in the Opening Up America Again guidelines.

Background and Summary

On April 16, 2020, the White House released the Opening Up America Again guideline (https://www.whitehouse.gov/openingamerica/), which outlines a three-phased approach to relaxing community mitigation measures currently in place to limit transmission of the SARS-CoV-2 virus. The purpose of the guideline is to outline a path to re-opening the economy while mitigating the risk of resurgence in COVID-19 illnesses and protecting vulnerable populations. The phased approach can be implemented on a statewide basis or community-by-community at governors' discretion. The guideline proposes the use of three categories of "gating" indicators (based on symptoms, based on cases, and for hospitals) to assess when to move through three community mitigation phases (Phase One, Phase Two, and Phase Three). Two gating indicators are in each category and include:

- *Indicators based on symptoms:*
  1. Downward trajectory of influenza-like illnesses (ILI syndrome) reported within a 14-day period

     AND
  2. Downward trajectory of COVID-like syndromic cases (i.e., COVID-like illness or CLI syndrome) reported within a 14-day period
- *Indicators based on cases:*
  3. Downward trajectory of documented COVID-19 cases within a 14-day period

     OR
  4. Downward trajectory of positive tests as a percent of total tests within a 14-day period (concurrent with a flat or increasing volume of tests)
- *Indicators for hospital readiness:*
  5. Capacity to treat all patients without utilization of crisis care standards

     AND
  6. Robust testing program in place for at-risk healthcare workers, including antibody testing

The Table at the end of the section summarizes all six indicators and the measures to support planning for transitioning through community mitigation phases. Indicators 1 through 4 rely on public health surveillance data to determine the trajectory of COVID-19 transmission within a jurisdiction. This document describes the measurement and interpretation of these four disease occurrence gating indicators. This document also highlights other disease occurrence measures that may be important for state or local jurisdictions to use when adjusting the intensity of community mitigation measures. Indicators 5 and 6 utilize hospital readiness measures to inform decision-making processes about readiness to move through mitigation phases. In addition to these indicators, CDC and CMS work collaboratively to provide guidance for reopening America. Further information on reopening of clinical facilities is available at https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf.

Disease Occurrence Gating Indicators

The following subsections provide further detail for each of the disease occurrence gating indicators outlined in the Opening Up America Again guideline, including a description and rationale, potential data sources, how to assess decreases (and moving through the three mitigation phases), how to assess increases (i.e., "rebound"), and interpreting each measure's strengths and limitations. Numerous data sources and surveillance systems exist at the local, state, and federal levels that can be used to measure and evaluate these indicators. Local and state officials should use the best data available, regardless of source, when assessing the trajectory of COVID-19 illnesses. Variability will exist from jurisdiction to jurisdiction in the quality, completeness, and timeliness of these data sources, and sufficient data may not be available for all jurisdictions to evaluate all four of the disease occurrence gating criteria. In situations where all the gating indicators cannot be assessed, additional data sources available locally may assist in determining the trajectory of COVID-19 activity in the jurisdiction.

Downward trajectory of ILI reported within a 14-day period

- **Description/Rationale:** ILI is a syndromic surveillance categorization applied to emergency department (ED) and outpatient visit symptom and diagnostic code data. This measure is intended to identify areas that are experiencing sustained decreases in outpatient clinic or ED visits in people with ILI. ILI is defined as fever with cough and/or a sore throat. COVID-19 may present with symptoms similar to ILI, so the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet) and the National Syndromic Surveillance Program (NSSP) can be used to track COVID-19 trends, especially when paired with SARS-CoV-2 and other respiratory pathogen testing data.
- **Data Sources:** Outpatient care facilities and hospital EDs selected by state and/or local health departments for participation in the Outpatient Influenza-Like Illness Network (ILINet) report to CDC either directly or through their health department via a web-based reporting system. In addition, electronic data, including data from CDC's NSSP can be uploaded to ILINet. These data are stored in a shared database for use by CDC and state/local public health officials. States and jurisdictions may collect syndromic surveillance data on ILI locally that is not submitted to ILINet but could be used in interpreting the ILI gating indicator. ILINet data is available publicly at the state-level at https://www.cdc.gov/flu/weekly/fluviewinteractive.htm.
- **Assessing Decreases:**
  - » To pass the criteria of a 14-day downward trajectory in ILI syndromic cases, a locality must either have experienced 14 days of decreasing cases or 14 days of minimal ILI activity. To determine a downward trajectory, the visits data are assessed using a smoothed curve to account for periodic fluctuations in ILI. To calculate this curve, CDC applies a cubic spline, or "smoothed curve", a statistical method that smooths out day-to-day variability in the data. The slope of this curve is used to assess declining incidence. Localities must have 14 days of consecutive downward slope, allowing for 2–3-day grace periods of increasing ILI to allow for irregularities. It is recommended that localities assess both the total counts of ILI visits and ILI visits as a percentage of total ED visits. Statistical coding used by CDC (using the R package) can be shared with state and local jurisdictions upon request.
  - » Normal variation in ILI ED and outpatient visits can affect the assessment of daily trends, especially in smaller geographies with low daily visits and by variations in healthcare seeking behavior associated with the day of the week, holidays, and current social distancing measures.
  - » ILI activity levels are traditionally calculated for jurisdictions based on the percent of outpatient visits due to ILI in a jurisdiction compared with the average percent of ILI visits that occur during weeks with little or no influenza virus circulation in that jurisdiction (i.e., non-influenza weeks), adjusted for the sites contributing data for the week. ILI activity values within two standard deviations of the non-influenza week mean are classified as a minimal level of ILI.

- » Given potential changes in healthcare seeking behaviors resulting from community mitigation measures that can significantly affect the denominator of ILI proportions, jurisdictions should analyze within-jurisdiction ILI trends using both the number (count) and proportion of visits to account for this potential bias.

- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the ILI gating indicator is met with respect to these phase transitions.
  - » Transition into Phase One: achieve 14 consecutive days (or two weeks) of downward trajectory or maintaining minimal ILI activity level.
  - » Transition into Phase Two: achieve an additional 14 consecutive days (or two weeks) of improvement (downward trajectory or minimal ILI activity level) without experiencing a rebound (defined below).
  - » Transition into Phase Three: achieve another 14 consecutive days (or two weeks) of improvement (downward trajectory or minimal ILI activity level) without experiencing a rebound (defined below).
- **Identifying Rebound:**
  - » An increase in ILI visits or an increase in ILI activity levels over 5 consecutive days may indicate a potential rebound in COVID-19 activity.
- **Interpretation/Limitations:**
  - » ILI is a nonspecific syndromic measure and can be influenced by the circulation of numerous respiratory pathogens and should be interpreted in the context of virologic and other surveillance data. For example, ILI is expected to fluctuate in the fall and winter due to circulation of seasonal influenza.
  - » The purpose of ILI surveillance is to detect changes in outpatient visits for febrile respiratory illness. The percent of patient visits for ILI can be affected by changes in health care seeking behavior, so jurisdictions should look at numbers (counts) of ILI visits in addition to proportions.
  - » ILI frequency and activity levels within a jurisdiction are influenced by the mix of primary care practice types submitting data. These changes make direct comparisons of ILI from one jurisdiction to another invalid. Calculation of ILI activity levels allows for more appropriate comparison of ILI between jurisdictions.

Downward trajectory of COVID-like illness (CLI) reported within a 14-day period

- **Description/Rationale:** CLI is a syndromic surveillance categorization applied to ED visit symptom and diagnostic code data. This measure is intended to identify areas that are experiencing sustained decreases in ED visits consistent with the presenting symptoms of COVID-19 illness (fever and either cough, shortness of breath, or difficulty breathing) or with a coronavirus diagnostic code that fits CDC interim coding guidelines, and without a diagnostic code for influenza (https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf). CLI can be used to track COVID-19 trends, especially when paired with SARS-CoV-2 and other respiratory pathogen testing data.
- **Data Sources:** Hospitals report ED visits in near real-time to state and/or local health departments and to NSSP. These data are stored within the BioSense Platform where they can be analyzed and exchanged by public health officials. States and jurisdictions may collect syndromic surveillance data on CLI locally that is not submitted to NSSP but could be useful for interpreting the CLI gating indicator.
- **Assessing Decreases:**
  - » To pass the criteria of a 14-day downward trajectory in CLI syndromic cases, a locality must either have experienced 14 days of decreasing cases or exhibit near pre-pandemic levels of CLI. To determine a downward trajectory, the visits data are assessed using a smoothed curve to account for periodic

fluctuations in CLI. To calculate this curve, CDC applies the cubic spline as with ILI and described above. The slope of this curve is used to assess declining incidence. Localities must have 14 days of consecutive downward slope, allowing for 2–3-day grace periods of increasing CLI to allow for irregularities. It is recommended that localities assess both the total counts of CLI visits and CLI visits as a percentage of total ED visits. Statistical coding used by CDC (using the R package) can be shared with state and local jurisdictions upon request.

  - » Normal variation in CLI ED visits affects the assessment of daily trends, especially in smaller geographies with low daily visits and by variations in healthcare seeking behavior associated with the day of the week, holidays, and current social distancing measures.

- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the CLI gating indicator is met with respect to these phase transitions.
  - » Transition into Phase One: achieve 14 consecutive days of improvement (downward trajectory or near pre-pandemic CLI ED visits).
  - » Transition into Phase Two: achieve an additional 14 consecutive days of improvement (downward trajectory or near pre-pandemic CLI ED visits) without experiencing a rebound (defined below).
  - » Transition into Phase Three: achieve another 14 consecutive days of improvement (downward trajectory or near pre- pandemic CLI ED visits) without experiencing a rebound (defined below).
- **Identifying Rebound:** Two primary methods can be used to help assess for a rebound in CLI ED visits.
  - » Within NSSP, daily statistical anomaly detection methods are automatically applied to time series trends, and anomalous increases are flagged for further epidemiologic investigation. Multiple consecutive days of anomalies may be an indicator of increases in COVID-19 activity and could be used to focus additional testing of patients.
  - » Regression methods (e.g., binomial regression) can be used to classify time series trends in the last 15 days to detect 5-day periods of significant increase in patients being seen with CLI and can also be used to focus additional investigations and/or confirmatory testing.
- **Interpretation/Limitations:**
  - » The purpose of syndromic surveillance is to find timely, more automated, indicators of a change in patterns of illness or health seeking behaviors in a community than is possible with case reporting. Syndromic data can initiate further confirmatory investigation. CLI is a non-specific syndromic measure and could be influenced by the circulation of other respiratory pathogens.
  - » The timeliest element of ED records is the patient chief complaint text describing their symptoms. The CLI syndrome is based in part on the patient's chief complaint at presentation to the ED, which may or may not actually be COVID-19, but also includes visits that were assigned a COVID-19 diagnosis code.
  - » The data quality and completeness of chief complaint text and diagnostic codes can vary by reporting hospital and can affect the assessment of trends over time.
  - » In general, syndromic categorizations emphasize timeliness and sensitivity over specificity. As such, the CLI gating indictor may exhibit changes earlier than other indicators but may also include visits for other illnesses that have similar symptoms as COVID-19 (e.g., infections with other respiratory viruses). Interpretation of CLI data should always be considered in conjunction with other data and the local context. Data that track the presence of other respiratory illnesses (e.g., respiratory syncytial virus and influenza) circulating within the community may help in assessing whether CLI is due to the virus that causes COVID-19 or other viruses.

Downward trajectory of documented (confirmed and probable) cases within a 14-day period

- **Description/Rationale:** On April 5, 2020, the Council of State and Territorial Epidemiologists (CSTE) issued an interim COVID-19 position statement making COVID-19 a nationally notifiable disease and establishing confirmed and probable case definitions (www.cste.org/resource/resmgr/2020ps/interim-20-id-01_covid-19.pdf). The case report gating indicator is intended to identify communities experiencing sustained decreases in the number of new cases occurring each day, an indication of decreases in disease transmission.
- **Data Sources:** Case report information for confirmed and probable cases collected by state and local jurisdictions and submitted to CDC; publicly available aggregated case count data (e.g., USAFacts: https://usafacts.org/visualizations/coronavirus-covid-19-spread-map/); US Census population estimates (used as denominator for incidence calculations)
- **Assessing criteria for reduction in number of cases:** To pass this criterion, a locality must either 1) have experienced 14 days of decreasing cases or 2) be in a low-incidence plateau. A locality that has a new outbreak or rebound cannot advance to the next phase unless they see another 14 days of decline.
- **Defining 14 days of decreasing cases:** To assess a downward trajectory, CDC uses a 3-day rolling average and applies a spline curve (described above). A period of 14 days of declining cases occurs when fewer cases are reported at the end of the 14 days compared with the number at the beginning of the period, using the 3-day rolling average fitted with the spline curve to define the number of cases. In addition, a "grace period" of 5 days may be applied during a downward trajectory, during which cases may increase for no more than 5 consecutive days. (If 5 days of consecutive increase occur, then the jurisdiction has met the criteria for rebound and is no longer in a downward trajectory.) Statistical coding used by CDC (using the R package) can be shared with state and local jurisdictions upon request.
- **Defining a low incidence plateau**
  - » A low-incidence plateau is defined as a very low number of new cases reported (below 10 cases per 100,000 population over 2 weeks) with only minimal change in daily cases.
  - » To qualify for this category, a locality must previously have seen elevated case counts.
- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the case report gating indicator is met with respect to these phase transitions. Note that the Opening Up America Again guideline specifies that either the case report gating indictor or the percent positive gating indicator should be met.
  - » Transition into Phase One: achieve 14 consecutive days of improvement (downward trajectory or near-zero incidence).
  - » Transition into Phase Two: achieve an additional 14 consecutive days of improvement (downward trajectory or near-zero incidence) without experiencing a rebound (defined below).
  - » Transition into Phase Three: achieve another 14 consecutive days of improvement (downward trajectory or near-zero incidence) without experiencing a rebound (defined below).
- **Defining rebound**
  - » A rebound occurs when the smoothed, 3-day average of case counts exhibits an increase over a 5 consecutive day period, following a downward trajectory of 14 or more days, including any grace period applied.

- **Interpretation/Limitations:**
  - » Case report data are a lagging indicator for assessing SARS-CoV-2 transmission in the community, as new cases are not identified until after the incubation period occurs, the ill person seeks testing or healthcare for their illness, and the information is reported to health officials.
  - » The choice of the dates used (e.g., onset date, report date) is critical in the interpretation of observed trends. If available, onset date is preferred because it improves timeliness of trend interpretation. However, because date of report is more likely to be available than date of illness onset, it is more frequently the date used to calculate trends. Whatever date is used, the assessment must account for the fact that very recent cases will not have been reported. Excluding recent onset dates or report dates (e.g., in the last 3 days or last week if onset dates are used) from assessment of trends should be considered to ensure that incomplete reporting of recent cases does not give the false appearance of downward trajectory.
  - » CDC analyses are typically based on the date of case report and not diagnosis or onset date because it is the most uniformly available date across jurisdictions. Preliminary analyses of national data show that there is typically an 8- to 10-day lag between the date of symptom onset and the date the case is reported to CDC, but this varies by jurisdiction.
  - » A sustained downward trajectory demonstrates improvement in daily case incidence but does not necessarily equate to a low disease burden. Communities should consider local resource capacity (e.g., availability of public health staff to conduct contact tracing) when determining appropriate incidence thresholds for making phase transition decisions.

Downward trajectory of positive tests as a percent of total tests within a 14-day period with stable or increasing test volume

- **Description/Rationale:** Laboratory test percent positive can be used in combination with, or as an alternative to, observing a decline in new case reports. In circumstances where testing is adequate and testing practices are largely stable, percent positive may be a reliable indicator of COVID-19 activity.
- **Data Sources:** Positive and negative SARS-CoV-2 test results reported by laboratories to state health departments. Data from the Census Bureau's Population Estimates Program can be used to estimate state and county population denominators for per-capita test rates.
- **Assessing Decreases:**
  - » Percent positive is calculated as the number of positive tests divided by the total test results, with total test results defined as the sum of positive tests and negative tests, excluding records where the test was not performed because the specimen was not usable or the test was cancelled. The number of tests with indeterminate results has been small, so not including these in the denominator of total test results should not affect interpretation of the trends observed.
  - » A jurisdiction must see a 14-day downward trajectory in percent positive (or near-zero percent positive) with up to 2–3 consecutive days of increasing or stable percent positive allowed as a grace period if data are inconsistent, while total test volume is stable or increasing.
  - » Methods to assess decreases in laboratory test positivity are similar to those used to assess decreases in ILI and CLI.
- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the percent positive gating indicator is met with respect to these phase transitions. Note that in the Opening Up America Again guideline, the case report gating indictor or the percent positive gating indicator should be met.
  - » Transition into Phase One: achieve 14 or more consecutive days of decline in percent positive (or near-zero percent positive) while total test volume is stable or increasing.

- » Transition into Phase Two: achieve an additional 14 or more consecutive days of decline in percent positive (or near-zero percent positive) while total test volume is stable or increasing.
- » Transition into Phase Three: achieve an additional 14 or more consecutive days of decline in percent positive (or near-zero percent positive) while total test volume is stable or increasing.
- » If a near-zero plateau has been reached, can meet if plateau is maintained over 14 consecutive days (2–3-day grace period)

- **Identifying Rebound:** Multi-day increases in percent positivity with stable or increasing testing volume should be assessed along with case report and CLI data to identify rebounds.
- **Interpretation/Limitations:**
  - » The daily percent positive may fluctuate, particularly in areas with smaller populations. Total test volume may also vary by day of the week, based on the number of tests ordered or regular system maintenance at laboratories.
  - » The percent positive is driven by the number of people who are positive in a community and the number of people who are tested. Declines in percent positive may result from an expansion of testing to more people. Thus, it is important to track percent positive in combination with the number tested, whether measured as the total volume of all test results, or as total test results per capita. Percent positivity should only be used as an indicator of COVID-19 activity when per capita testing levels are stable over the time period being assessed.
  - » The percent positive may also be affected by a changing proportion of tests in people who are less likely to be infected, such as those who are asymptomatic or who have less severe symptoms. Few laboratories have fields indicating whether the person tested was asymptomatic or whether the patient was in an inpatient or outpatient setting at the time of testing. However, communities can stratify by data source to assess changes in the population tested over time, such as tracking the percent positive in hospital data separately from the percent positive in large commercial laboratories.
  - » The residence of the person tested may not be validated as thoroughly in laboratory data as in case data. Patient zip code may be based on insurance billing data, and thus less likely to be complete and correct when the person tested is uninsured or on another family member's plan.
  - » Provider zip code is generally accurate, when available. However, drive-up facilities might use a central zip code that does not reflect where the physical drive-up facility is located.

Joint interpretation of all four disease occurrence gating criteria

The four disease occurrence gating indicators should be interpreted collectively to reach a determination on the trajectory of COVID-19 activity within a jurisdiction, bearing in mind that the measures differ significantly in their lag, specificity, and sensitivity. Lab testing and syndromic data sources generally have less lag than COVID-19 case report data relative to when transmission occurred. SARS-CoV-2 testing and COVID-19 case reports are more specific measures of COVID-19 activity than the CLI syndrome, but all three are likely far more specific than the ILI syndrome. The CLI syndrome likely has superior sensitivity to the other measures, as it is more likely to capture people with COVID-19 that were not tested. While downward trajectory for a period of 14 days is used for each of the disease occurrence gating indicators in the Opening Up America Again guideline, state and local jurisdictions should use judgment based on their knowledge of local disease surveillance practices and infrastructure in determining whether longer time periods (e.g., 21 or 28 days) are needed before moving to different community mitigation phases.

Other Data Sources and Measures

The four disease occurrence gating indicators above provide insight into both the intensity and trajectory of the COVID-19 pandemic within jurisdictions. In addition, other epidemiologic data sources are available to local, state, and federal health officials and can be used to confirm trends observed in the disease occurrence gating indicators.

- **COVID-19 hospital admissions:** Depending on the overall COVID-19 incidence rate, the size of the jurisdiction, and the regional hospital referral patterns, hospitalizations for laboratory-confirmed COVID-19 can be an important measure to assess trajectory. Testing is likely more complete and less variable in hospitalized populations, providing more assurance that observed trends are not driven by testing practices. In addition to helping verify increases or decreases in the disease occurrence gating indicators, monitoring COVID-19 hospital admissions (and discharges) can help assess the burden on local healthcare capacity.
- **COVID-19 deaths:** Depending on the overall COVID-19 incidence rate and the size of the jurisdiction, deaths due to COVID-19 may occur in high enough numbers to reliably assess the trajectory of the outbreak in the jurisdiction. Although they represent a small proportion of all COVID-19 illnesses and significantly lag the core disease occurrence gating indicators, vital records are a universally collected data source and should be available for review in all jurisdictions. Further, observing declines in newly reported COVID-19 deaths almost certainly indicates that demands on the healthcare system are waning. Care should be taken to understand the extent and variability in SARS-CoV-2 testing for deceased individuals in the jurisdiction when using death as a source of data to understand the overall trajectory of COVID-19 illnesses in the jurisdiction. COVID-19 death data reported to CDC's National Center for Health Statistics are published weekly by state (https://www.cdc.gov/nchs/nvss/vsrr/covid19/index.htm).
- **Measures of trajectory:** The effective reproductive number (the average number of secondary cases from an infectious case in an a particular population at a specific point in time) and doubling time (the time required for the number of cases to double) are epidemiologic measures that can be used to characterize the speed with which illnesses are spreading in an outbreak. Although these measures can be imprecise, especially when calculated within smaller populations, they provide alternative ways to analyze and characterize the trajectory of COVID-19 activity.

Implied in the Core State Preparedness Responsibilities in the *Opening Up America Again* guideline is the need for jurisdictions to have confidence in the epidemiologic data being used to make assessments about the magnitude and trajectory of COVID-19 illnesses. In order for most of the gating indicators to be reliably assessed, 1) rapid testing should be occurring as indicated for all clinical, public health, and infection prevention needs and 2) all new symptomatic COVID-19 cases in the jurisdiction should be able to be rapidly identified through active surveillance of laboratories and healthcare facilities. In the absence of widespread testing and robust active surveillance, jurisdictions should be cautious when adjusting mitigation strategies based on the disease occurrence gating indicators. Several measures, listed below, can be helpful in providing an indirect assessment of the completeness of case ascertainment in a jurisdiction.

- COVID-19 case-fatality ratio: Case-fatality is defined as the proportion of COVID-19 cases result in death. Although estimates of the percentage of symptomatic COVID-19 illnesses that result in death has varied widely, the overall percentage is likely lower than 1–2%. Although many factors contribute to disease severity, including the underlying health status of the population, jurisdictions that have very high COVID-19 case-fatality ratios (above 5–10%) may be under-ascertaining COVID-19 illnesses. This could indicate that case reporting is an unreliable measure of true COVID-19 activity. In this situation it may be useful to examine measures for CLI syndrome or COVID-19 hospital admissions as measures of disease activity.

- High percent positive: Although changes in percent positive is an indicator in the Opening Up America Again guideline, very high proportions of SARS-CoV-2 positivity (e.g., >25%) may be an indicator that testing levels are not adequate and that COVID-19 illnesses are being under-ascertained in the jurisdiction, as it suggests that only a limited number of people with a high likelihood of being infected with SARS-CoV-2 are able to be tested. In this situation it also may useful to look at the CLI syndrome or at COVID-19 hospital admissions as measures of disease activity, since they are likely less susceptible to the influence of testing availability.
- Per capita testing: It is difficult to determine a widely applicable benchmark for a per capita level of SARS-CoV-2 testing that is sufficient to have confidence in the adequacy of COVID-19 case-ascertainment. However, jurisdictions can consider evaluating their per capita testing to assist in judging whether testing levels are adequate for effective COVID-19 surveillance.
- Proportion of cases with an unknown source: Improvements in case ascertainment and contact tracing should lead to a lower proportion of new cases with an unknown exposure to SARS-CoV-2. Jurisdictions can consider tracking the proportion of new COVID-19 cases without a documented exposure source (e.g., travel to a high-incidence region or country, exposure to someone with a confirmed case of COVID-19, attending and event or going to a setting with suspected SARS-CoV-2 transmission). Although difficult to achieve, jurisdictions that have fewer than 50% of new cases with an unknown exposure source likely have likely achieved high levels of case ascertainment, interviewing, and contact tracing.

Hospital Indicators

Capacity to treat all patients without crisis care

- **Description/Rationale:** Capacity indicators, including percentage of inpatients and ICU beds occupied and PPE supplies, help identify areas where additional healthcare capacity needs may exist now or in the future.
- **Data sources:** Data within HHS Protect, including from CDC's National Healthcare Safety Network (NHSN) (a healthcare infection associated tracking system), provide information on inpatient and ICU bed occupancy, staffing shortages, and PPE supplies.
- **Assessing indicator:** All three measures of treating patients without crisis care should be met before a jurisdiction moves to the next community mitigation phase.
- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the hospital indicators are met with respect to these phase transitions.
  - » Transition into Phase One: Inpatient and ICU beds <80% full for 7 consecutive days AND no staff shortages for 7 consecutive days AND PPE supplies adequate and available for >4 days.
  - » Transition into Phase Two: Inpatient and ICU beds <75% full for 7 consecutive days AND no staff shortages for 7 consecutive days AND PPE supplies adequate and available for >4 days.
  - » Transition into Phase Three: Inpatient and ICU beds <70% full for 7 consecutive days AND no staff shortages for 7 consecutive days AND PPE supplies adequate and available for >15 days.
- **Interpretation/Limitations:**
  - » Hospitals within the same jurisdiction may be at different stages with regard to these measures. Public health officials should assess the status of the jurisdiction's hospital capacity overall and consider whether resources (e.g., clinical staff, PPE) could be re-allocated to address differential needs.

Robust testing program

- **Description/Rationale:**
  - » The percentage of positive diagnostic tests for SARS-CoV-2 can be used as an indirect measure of agreement between testing demand and test availability. A target frequency of negative tests (e.g., 80% negative) must be established as an indicator of "adequate" availability of tests. This threshold can then be used to monitor for regional shortages and target distribution of testing resources to areas with greatest need.
  - » Timeliness of results is another measure of laboratory testing capacity, and prompt results are essential for effective contact tracing.
- **Data sources:** Positive and negative SARS-CoV-2 test results reported by laboratories to state health departments. Median time between test order and results can be calculated from the reported laboratory data.
- **Assessing indicator:** Both criteria for a robust testing program should be met before a jurisdiction moves to the next community mitigation phase. The metric for percentage positive tests can be assessed as the percentage of positive of viral tests among all tests with a result for 14 consecutive days. An alternative would be to have daily percent positive below the phase transition threshold for 14 consecutive days.
- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the indicators for a robust testing program are met with respect to these phase transitions.
  - » Transition into Phase One: Percentage positive tests ≤20% for 14 days AND median time from test order to result <4 days.
  - » Transition into Phase Two: Percentage positive tests ≤15% for 14 days AND median time from test order to result <3 days.
  - » Transition into Phase Three: Percentage positive tests ≤10% for 14 days AND median time from test order to result <2 days.
- **Interpretation/Limitations:**
  - » This indicator refers to tests for current infection (e.g., nucleic acid (PCR) or antigen tests). Serology (i.e., antibody) testing metrics should not be used for this indicator.
  - » Lags in test reporting may lead to incomplete data for calculating percent positive tests for the most recent few days. Jurisdictions should calculate percent positive for the most recent 14 days with near-complete testing data.

Additional Considerations

Overall Incidence Level

The disease occurrence gating indicators all pertain to assessing the trajectory of COVID-19 activity, but do not specify that COVID-19 incidence should reach an absolute level to move through the mitigation phases. Jurisdictions should be cautious in pivoting from a general community mitigation approach back toward an identification and containment approach until incidence is low enough and resources adequate to 1) attempt an initial interview for nearly all new COVID-19 cases within one day of health department notification, 2) to rapidly isolate all newly identified COVID-19 cases, and 3) to initiate appropriate follow up (isolation, self-monitoring, and rapid testing of symptomatic contacts) for nearly all identified contacts of newly identified cases. Incidence should also be low enough that health departments can respond to large outbreaks (e.g., nursing home outbreaks)

that require substantial resources to investigate and control. Declines in incidence should also be enough for healthcare capacity to not only meet current demands, but to be able to comfortably surge in the event of an increase in cases (e.g., availability of acute care beds, critical care beds, ventilators, and adequate PPE).

Special Populations and Settings

Infections in high-risk settings and populations can disproportionately impact localized transmission and the ability of public health capacity to keep pace with follow up needs such as contract tracing and screening. Efforts should be taken to monitor infections in some specific populations and settings, including but not limited to healthcare personnel, patients in healthcare facilities (e.g., nursing homes, dialysis centers, long term care facilities), and residents of congregate living settings (e.g., prisons, youth homes, shelters). In addition, identification of illnesses at work places (e.g., meat and poultry processing facilities) or events with the potential for "explosive spread" (e.g., mass gatherings) may warrant adjustment of community mitigation measures in the absence of community-wide changes in the disease occurrence gating indicators.

Neighboring Jurisdictions

When making decisions about adjusting community mitigation measures, state and local jurisdictions also should coordinate with officials in neighboring areas to assess the burden and trajectory of COVID-19 illnesses in the surrounding region. Neighboring or nearby jurisdictions with significantly higher incidence or with increasing COVID-19 activity could reintroduce SARS-CoV-2 to a jurisdiction, jeopardizing improvements within the jurisdiction.

Measures of Mobility and Social Distancing

If available, it may be important to understand the knowledge, attitudes and behaviors of the community as it relates to the public health guidance provided within the local jurisdiction. Survey data and data on mobility can be useful in understanding if community members are aware of and following established social distancing and isolation guidelines and informing changes in the mitigation strategies used. Several publicly available data sources currently exist that generate measures of social distancing and mobility, frequently based on mobile phone location services or social media data.

Summary

The disease occurrence gating indicators in the *Opening Up America Again* guideline provide states and communities insight into the trajectory of the COVID-19 pandemic in their jurisdiction. The disease occurrence gating indicators should be evaluated collectively, considering their relative strengths and weaknesses, in the context of other epidemiologic data available for the jurisdiction. The hospital indicators are designed to help decision makers understand the health system's ability to handle a potential surge in cases. These indicators are part of the broad assessment jurisdictions should undertake when deciding when and how to adjust community mitigation strategies for COVID-19.

Table 5. Gating Criteria Summary

Gating Criteria	Threshold for entering Phase 1	Threshold for entering Phase 2	Threshold for entering Phase 3
Decreases in ED and/or outpatient visits for influenza-like illness (ILI) Decreases in ED and/or outpatient visits for COVID-like illness (CLI)	Downward trajectory of ILI/CLI (or minimal ILI activity or near pre-pandemic level of CLI ED visits) reported over a 14-day period • Uses a 3-day average in a cubic smoothing spline • 14 consecutive days of decline required but can use a 2–3 day grace period if data are inconsistent • Look at both total visits for ILI/CLI and percentage of visits for ILI/CLI • 14th day must be lower than 1st day • If near pre-pandemic level of CLI ED visits has been reached, can meet if pre-pandemic level is maintained over 14 consecutive days (2–3 day grace period)	Downward trajectory of ILI/CLI (or minimal ILI activity or near pre-pandemic level of CLI ED visits) reported for at least 14 days after entering Phase 1 without experiencing a rebound • Same criteria but for a second 14-day period • Rebound is determined if the trajectory increases in a 5-day period	Downward trajectory of ILI/CLI (or minimal ILI activity or near pre-pandemic level of CLI ED visits) reported for at least an additional 14 days after entering Phase 2 without experiencing a rebound • Same criteria but for a second 14-day period • Rebound is determine if the trajectory increases in a 5-day period

Continued on the next page ▸

Gating Criteria	Threshold for entering Phase 1	Threshold for entering Phase 2	Threshold for entering Phase 3
Decreases in newly identified COVID-19 cases	Downward trajectory (or near-zero incidence) of documented cases over a 14-day period • Uses a 3-day average in a cubic smoothing spline • 14 consecutive days of decline required but can use up to a 5-day grace period if data are inconsistent • 14th day must be lower than 1st day • To be near-zero incidence, must have fewer than 10 cases per 100k population over 14 days) and must have previously had elevated cases	Downward trajectory (or near-zero incidence) of documented cases for at least 14 days after entering Phase 1 • Same criteria as Phase 1 for another 14 days • Rebound is defined as having 5 consecutive days of increase	Downward trajectory (or near-zero incidence) of documented cases for at least 14 days after entering Phase 2 • Same criteria as Phase 2 for another 14 days • Rebound is defined as having 5 consecutive days of increase
Decreases in newly identified COVID-19 cases	Downward trajectory (or near-zero incidence) of documented cases over a 14-day period • Uses a 3-day average in a cubic smoothing spline • 14 consecutive days of decline required but can use up to a 5-day grace period if data are inconsistent • 14th day must be lower than 1st day • To be near-zero incidence, must have fewer than 10 cases per 100k population over 14 days) and must have previously had elevated cases	Downward trajectory (or near-zero percent positive) of positive tests as a percent of total tests for 14 days after entering Phase 1 (flat or increasing volume of tests) • Same criteria as Phase 1 for another 14 days • Rebound is defined as having multi-day increases in percent positivity with stable or increasing testing volume. • Look at positive results and cases when assessing for rebound	Downward trajectory (or near-zero percent positive) of positive tests as a percent of total tests for at least 14 days after entering Phase 2 (flat or increasing volume of tests) • Same criteria as Phase 1 for another 14 days • Rebound is defined as having multi-day increases in percent positivity with stable or increasing testing volume. • Look at positive results and cases when assessing for rebound

Continued on the next page ▸

Gating Criteria	Threshold for entering Phase 1	Threshold for entering Phase 2	Threshold for entering Phase 3
Decreases in percentage of SARS-CoV-2 tests positive	Downward trajectory (or near-zero percent positive) of positive tests as a percent of total tests over a 14-day period (flat or increasing volume of tests) • Divide total positive results by total positive + negative • Remove incomplete and inconclusive results • 14 consecutive days of downward trend with up to 2–3 consecutive days of a grace period due to data inconsistency • 14th day must be lower than 1st day • If a near-zero plateau has been reached, can meet if plateau is maintained over 14 consecutive days (2–3 day grace period) • Test volume must remain the same or be increasing to use this criterion • Should include all test results from all labs	Downward trajectory (or near-zero percent positive) of positive tests as a percent of total tests for 14 days after entering Phase 1 (flat or increasing volume of tests) • Same criteria as Phase 1 for another 14 days • Rebound is defined as having multi-day increases in percent positivity with stable or increasing testing volume. • Look at positive results and cases when assessing for rebound	Downward trajectory (or near-zero percent positive) of positive tests as a percent of total tests for at least 14 days after entering Phase 2 (flat or increasing volume of tests) • Same criteria as Phase 1 for another 14 days • Rebound is defined as having multi-day increases in percent positivity with stable or increasing testing volume. • Look at positive results and cases when assessing for rebound
Treat all patients without crisis care	Jurisdiction inpatient & ICU beds <80% full Staff shortage in last week = no PPE supplies adequate for >4 days	Jurisdiction inpatient & ICU beds <75% full Staff shortage in last week = no PPE supplies adequate for >4 days	Jurisdiction inpatient & ICU beds <70% full Staff shortage in last week = no PPE supplies adequate for >15 days
Robust testing program	Test availability such that % positive tests <20% for 14 days Median time from test order to result <4 days	Test availability such that % positive tests <15% for 14 days Median time from test order to result <3 days	Test availability such that % positive tests <10% for 14 days Median time from test order to result <2 days

Appendix F: Setting Specific Guidance

CDC offers this interim guidance to assist establishments as they open. CDC will update this guidance as it learns more about COVID-19 and best practices to prevent its spread.

This guidance is meant to supplement the decision tools CDC released on May 14, 2020. It lists specific practices that employers may find helpful at particular stages of the COVID-19 outbreak. This guidance sets forth a menu of safety measures, from which establishments may choose those that make sense for them in the context of their operations and local community, as well as state and local regulations and directives.

INTERIM GUIDANCE FOR CHILD CARE PROGRAMS

The gradual scale up of activities towards pre-COVID-19 operating practices at childcare programs is crucial to helping parents and guardians return to work. Many states have closed schools for the academic year and, with summer quickly approaching, an increasing number of working parents may need to rely on these programs. CDC's Interim Guidance for Administrators of US K-12 Schools and Child Care Programs and supplemental Guidance for Child Care Programs that Remain Open provide recommendations for operating childcare programs in low, moderate, and significant mitigation communities. In communities that are deemed significant mitigation areas by state and local authorities, childcare programs should be closed. However, childcare programs can choose to remain open to serve children of essential workers, such as healthcare workers. All decisions about following these recommendations should be made locally, in collaboration with local health officials who can help determine levels of COVID-19 community transmission and the capacities of the local public health system and healthcare systems. CDC is releasing this interim guidance, laid out in a series of three steps, to inform a gradual scale up of operations. The scope and nature of community mitigation suggested decreases from Step 1 to Step 3. Some amount of community mitigation is necessary across all steps until a vaccine or therapeutic drug becomes widely available.

Scaling Up Operations

- **In all Steps:**
  - » Establish and maintain communication with local and State authorities to determine current mitigation levels in your community.
  - » Protect and support staff, children, and their family members who are at higher risk for severe illness.
  - » Provide staff from higher transmission areas (earlier Step areas) telework and other options as feasible to eliminate travel to childcare programs in lower transmission (later Step) areas and vice versa.
  - » Follow CDC's supplemental Guidance for Child Care Programs that Remain Open.
  - » Encourage any other community groups or organizations that use the childcare facilities also follow this guidance.
- **Step 1:** Restrict to children of essential workers.
- **Step 2:** Expand to all children with enhanced social distancing measures.
- **Step 3:** Remain open for all children with social distancing measures.

Safety Actions

Promote healthy hygiene practices (Steps 1–3)

- Teach and reinforce washing hands and covering coughs and sneezes among children and staff.
- Teach and reinforce use of cloth face coverings among all staff. Face coverings are most essential at times when social distancing is not possible. Staff should be frequently reminded not to touch the face covering and to wash their hands frequently. Information should be provided to all staff on proper use, removal, and washing of cloth face coverings.
- Have adequate supplies to support healthy hygiene behaviors, including soap, hand sanitizer with at least 60 percent alcohol (for staff and older children who can safely use hand sanitizer), paper towels, and tissues.
- Post signs on how to stop the spread of COVID-19, properly wash hands, promote everyday protective measures, and properly wear a face covering.

Intensify cleaning, disinfection, and ventilation (Steps 1–3)

- Clean, sanitize, and disinfect frequently touched surfaces (for example, playground equipment, door handles, sink handles, drinking fountains) multiple times per day and shared objects between use.
- Avoid use of items (for example, soft or plush toys) that are not easily cleaned, sanitized, or disinfected.
- Ensure safe and correct application of disinfectants and keep products away from children.
- Ensure that ventilation systems operate properly and increase circulation of outdoor air as much as possible such as by opening windows and doors. Do not open windows and doors if doing so poses a safety or health risk (for example, allowing pollens in or exacerbating asthma symptoms) to children using the facility.
- Take steps to ensure that all water systems and features (for example, drinking fountains or decorative fountains) are safe to use after a prolonged facility shutdown to minimize the risk of Legionnaires' disease and other diseases associated with water.

Promote social distancing

- **Steps 1 and 2**
  - » Ensure that classes include the same group of children each day and that the same childcare providers remain with the same group each day, if possible.
  - » Restrict mixing between groups.
  - » Cancel all field trips, inter-group events, and extracurricular activities (Step 1).
  - » Limit gatherings, events, and extracurricular activities to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from higher transmission areas (Step 2; Note: restricting attendance from those in Step 1 areas).
  - » Restrict nonessential visitors, volunteers, and activities involving other groups at the same time.
  - » Space out seating and bedding (head-to-toe positioning) to 6 feet apart if possible.
  - » Close communal use spaces, such as game rooms or dining halls, if possible; if this is not possible, stagger use and disinfect in between uses.
  - » If a cafeteria or group dining room is typically used, serve meals in classrooms instead. Put each child's meal on a plate, to limit the use of shared serving utensils and ensure the safety of children with food allergies.
  - » Stagger arrival and drop-off times or put in place other protocols to limit direct contact with parents as much as possible.

- **Step 3**
  - » Consider keeping classes together to include the same group of children each day, and consider keeping the same childcare providers with the same group each day.
  - » Allow minimal mixing between groups. Limit gatherings, events, and extracurricular activities to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from higher transmission areas (Step 1 or 2 areas).
  - » Continue to space out seating and bedding (head-to-toe positioning) to 6 feet apart, if possible.
  - » Consider keeping communal use spaces closed, such as game rooms, playgrounds, or dining halls, if possible; if this is not possible, stagger use and disinfect in between uses.
  - » Consider continuing to plate each child's meal, to limit the use of shared serving utensils and ensure the safety of children with food allergies.
  - » Consider limiting nonessential visitors, volunteers, and activities involving other groups. Restrict attendance of those from higher transmission areas (Step 1 or 2 areas).
  - » Consider staggering arrival and drop-off times or putting in place other protocols to limit close contact with parents or caregivers as much as possible.
- **Limit sharing** (Steps 1–3)
  - » Keep each child's belongings separated and in individually labeled storage containers, cubbies, or areas and taken home each day and cleaned, if possible.
  - » Ensure adequate supplies to minimize sharing of high-touch materials to the extent possible (art supplies, equipment etc. assigned to a single child) or limit use of supplies and equipment by one group of children at a time and clean and disinfect between use.
  - » If food is offered at any event, have pre-packaged boxes or bags for each attendee instead of a buffet or family-style meal.
  - » Avoid sharing of foods and utensils.
  - » Avoid sharing electronic devices, toys, books, other games, and learning aids.
  - » Prevent risk of transmitting COVID-19 by avoiding immediate contact (such as shaking or holding hands, hugging, or kissing).
- Train all staff (Steps 1–3)
  - » Train all staff in the above safety actions. Consider conducting the training virtually, or, if in-person, ensure social distancing is maintained.

Monitoring and Preparing

Check for signs and symptoms (Steps 1–3)

- Screen children upon arrival, if possible. Establish routine, daily health checks on arrival, such as temperature screening of both staff and children. Options for daily health check screenings for children are provided in CDC's supplemental Guidance for Child Care Programs that Remain Open and in CDC's General Business FAQs for screening staff.
- Implement health checks (e.g. temperature checks and symptom screening) screenings safely and respectfully, and with measures in place to ensure confidentiality as well as in accordance with any applicable privacy laws or regulations. Confidentiality should be maintained.

- Employers and childcare directors may use examples of screening methods in CDC's supplemental Guidance for Child Care Programs that Remain Open as a guide.
- Encourage staff to stay home if they are sick and encourage parents to keep sick children home.

Plan for when a staff member, child, or visitor becomes sick (Steps 1–3)

- Identify an area to separate anyone who exhibits COVID-like symptoms during hours of operation, and ensure that children are not left without adult supervision.
- Establish procedures for safely transporting anyone sick to their home or to a healthcare facility, as appropriate.
- Notify local health officials, staff, and families immediately of any possible case of COVID-19 while maintaining confidentiality consistent with the Americans with Disabilities Act (ADA) and other applicable federal and state privacy laws.
- Close off areas used by any sick person and do not use them until they have been cleaned. Wait 24 hours before you clean or disinfect to reduce risk to individuals cleaning. If it is not possible to wait 24 hours, wait as long as possible. Ensure safe and correct application of disinfectants, and keep disinfectant products away from children
- Advise sick staff members or children not to return until they have met CDC criteria to discontinue home isolation.
- Inform those who have had close contact to a person diagnosed with COVID-19 to stay home and self-monitor for symptoms, and to follow CDC guidance if symptoms develop. If a person does not have symptoms follow appropriate CDC guidance for home isolation.

Maintain healthy operations (Steps 1–3)

- Implement flexible sick leave policies and practices, if feasible.
- Monitor absenteeism to identify any trends in employee or child absences due to illness. This might indicate spread of COVID-19 or other illness. Have a roster of trained back-up staff in order to maintain sufficient staffing levels.
- Designate a staff person to be responsible for responding to COVID-19 concerns. Employees should know who this person is and how to contact them.
- Create a communication system for staff and families for self-reporting of symptoms and notification of exposures and closures.
- Support coping and resilience among employees and children.

Steps 1–3

- It is very important to check State and local health department notices daily about spread of COVID-19 in the area and adjust operations accordingly.
- Where a community is deemed a significant mitigation community, childcare programs should close, except for those caring for the children of essential workers, such as the children of health care workers.
- In the event a person diagnosed with COVID-19 is determined to have been in the building and poses a risk to the community, programs may consider closing for a few days for cleaning and disinfection.

INTERIM GUIDANCE FOR SCHOOLS AND DAY CAMPS

As communities consider a gradual scale up of activities towards pre-COVID-19 operating practices in centers for learning, such as K–12 schools and summer day camps, CDC offers the following recommendations to keep communities safe while resuming peer-to-peer learning and providing crucial support for parents and guardians returning to work. These recommendations depend on community monitoring to prevent COVID-19 from spreading. Communities with low levels of COVID-19 spread and those with confidence that the incidence of infection is genuinely low (e.g., communities that remain in low transmission or that have entered Step 2 or 3) may put in place the practices described below as part of a gradual scale up of operations. All decisions about following these recommendations should be made in collaboration with local health officials and other state and local authorities who can help assess the current level of mitigation needed based on levels of COVID-19 community transmission and the capacities of the local public health and healthcare systems, among other relevant factors. CDC is releasing this interim guidance, laid out in a series of three steps, to inform a gradual scale up of operations. The scope and nature of community mitigation suggested decreases from Step 1 to Step 3. Some amount of community mitigation is necessary across all steps until a vaccine or therapeutic drug becomes widely available.

Scaling Up Operations

- **In all Steps:**
  - » Establish and maintain communication with local and state authorities to determine current mitigation levels in your community.
  - » Protect and support staff and students who are at higher risk for severe illness, such as providing options for telework and virtual learning.
  - » Follow CDC's Guidance for Schools and Childcare Programs.
  - » Provide teachers and staff from higher transmission areas (earlier Step areas) telework and other options as feasible to eliminate travel to schools and camps in lower transmission (later Step) areas and vice versa.
  - » Encourage any other external community organizations that use the facilities also follow this guidance.
- **Step 1:** Schools that are currently closed, remain closed. E-learning or distance learning opportunities should be provided for all students. Support provision of student services such as school meal programs, as feasible. Camps should be restricted to children of essential workers and for children who live in the local geographic area only.
- **Step 2:** Remain open with enhanced social distancing measures and for children who live in the local geographic area only.
- **Step 3:** Remain open with distancing measures. Restrict attendance to those from limited transmission areas (other Step 3 areas) only.

Safety Actions

Promote healthy hygiene practices (Steps 1–3)

- Teach and reinforce washing hands and covering coughs and sneezes among children and staff.
- Teach and reinforce use of face coverings among all staff. Face coverings may be challenging for students (especially younger students) to wear in all-day settings such as school. Face coverings should be worn by staff and encouraged in students (particularly older students) if feasible and are most essential in times when

physical distancing is difficult. Information should be provided to staff and students on proper use, removal, and washing of cloth face coverings. Face coverings are not recommended for babies or children under the age of 2, or for anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the covering without assistance. Cloth face coverings are meant to protect other people in case the wearer is unknowingly infected (many people carry COVID-19 but do not have symptoms). Cloth face coverings are not surgical masks, respirators, or personal protective equipment.

- Have adequate supplies to support healthy hygiene behaviors, including soap, hand sanitizer with at least 60 percent alcohol (for staff and older children who can safely use hand sanitizer), paper towels, tissues, and no-touch trash cans.
- Post signs on how to stop the spread of COVID-19, properly wash hands, promote everyday protective measures, and properly wear a face covering.

Intensify cleaning, disinfection, and ventilation (Steps 1–3)

- Clean and disinfect frequently touched surfaces within the school and on school buses at least daily (for example, playground equipment, door handles, sink handles, drinking fountains) as well as shared objects (for example, toys, games, art supplies) between uses.
- To clean and disinfect school buses, see guidance for bus transit operators.
- Ensure safe and correct application of disinfectants and keep products away from children.
- Ensure ventilation systems operate properly and increase circulation of outdoor air as much as possible such as by opening windows and doors. Do not open windows and doors if they pose a safety or health risk (e.g., allowing pollens in or exacerbating asthma symptoms) risk to children using the facility.
- Take steps to ensure that all water systems and features (for example, drinking fountains, decorative fountains) are safe to use after a prolonged facility shutdown to minimize the risk of Legionnaires' disease and other diseases associated with water.

Promote social distancing

- **Step 1 and 2**
  - » Ensure that student and staff groupings are as static as possible by having the same group of children stay with the same staff (all day for young children, and as much as possible for older children).
  - » Restrict mixing between groups.
  - » Cancel all field trips, inter-group events, and extracurricular activities (Step 1).
  - » Limit gatherings, events, and extracurricular activities to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from higher transmission areas (Step 2; Note: restricting attendance from those in Step 1 areas).
  - » Restrict nonessential visitors, volunteers, and activities involving other groups at the same time.
  - » Space seating/desks to at least 6 feet apart.
  - » Turn desks to face in the same direction (rather than facing each other), or have students sit on only one side of tables, spaced apart.
  - » Close communal use spaces such as dining halls and playgrounds if possible; otherwise stagger use and disinfect in between use.
  - » If a cafeteria or group dining room is typically used, serve meals in classrooms instead. Serve individually plated meals and hold activities in separate classrooms and ensure the safety of children with food allergies.

- » Stagger arrival and drop-off times or locations, or put in place other protocols to limit close contact with parents or caregivers as much as possible.
- » Create social distance between children on school buses (for example, seating children one child per seat, every other row) where possible.

- **Step 3**
  - » Consider keeping classes together to include the same group of children each day, and consider keeping the same child care providers with the same group each day.
  - » Allow minimal mixing between groups. Limit gatherings, events, and extracurricular activities to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from higher transmission areas (Step 1 or 2 areas).
  - » Continue to space out seating and bedding (head-to-toe positioning) to 6 feet apart, if possible.
  - » Consider keeping communal use spaces closed, such as game rooms or dining halls, if possible; if this is not possible, stagger use and disinfect in between uses.
  - » Consider continuing to plate each child's meal, to limit the use of shared serving utensils and ensure the safety of children with food allergies.
  - » Consider limiting nonessential visitors, volunteers, and activities involving other groups. Restrict attendance of those from higher transmission areas (Step 1 or 2 areas).
  - » Consider staggering arrival and drop-off times or locations, or put in place other protocols to limit close contact with parents or caregivers as much as possible.

Limit sharing (Steps 1–3)

- Keep each child's belongings separated from others' and in individually labeled containers, cubbies, or areas and taken home each day and cleaned, if possible.
- Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single student/camper) or limit use of supplies and equipment by one group of children at a time and clean and disinfect between use.
- If food is offered at any event, have pre-packaged boxes or bags for each attendee instead of a buffet or family-style meal. Avoid sharing of foods and utensils.
- Avoid sharing electronic devices, toys, books, and other games or learning aids.

Train all staff (Steps 1–3)

- Train all teachers and staff in the above safety actions. Consider conducting the training virtually, or, if in-person, ensure that social distancing is maintained.

Check for signs and symptoms (Steps 1–3)

- If feasible, conduct daily health checks (e.g. temperature screening and/or symptoms checking) of staff and students safely, respectfully, as well as in accordance with any applicable privacy laws or regulations. Confidentiality should be maintained.
- School and camp administrators may use examples of screening methods in CDC's supplemental Guidance for Child Care Programs that Remain Open as a guide for screening children and CDC's General Business FAQs for screening staff.
- Encourage staff to stay home if they are sick and encourage parents to keep sick children home.

Plan for when a staff member, child, or visitor becomes sick (Steps 1–3)

- Work with school administrators, nurses, and other healthcare providers to identify an isolation room or area to separate anyone who exhibits COVID-like symptoms. School nurses and other healthcare providers should use Standard and Transmission-Based Precautions when caring for sick people. See: What Healthcare Personnel Should Know About Caring for Patients with Confirmed or Possible COVID-19 Infection.
- Establish procedures for safely transporting anyone sick home or to a healthcare facility.
- Notify local health officials, staff, and families immediately of a possible case while maintaining confidentiality consistent with the Americans with Disabilities Act (ADA) and other applicable federal and state privacy laws.
- Close off areas used by a sick person and do not use before cleaning and disinfection. Wait 24 hours before you clean and disinfect. If it is not possible to wait 24 hours is, wait as long as possible. Ensure safe and correct application of disinfectants and keep disinfectant products away from children.
- Advise sick staff members and children not to return until they have met CDC criteria to discontinue home isolation.
- Inform those who have had close contact to a person diagnosed with COVID-19 to stay home and self-monitor for symptoms and to follow CDC guidance if symptoms develop. If a person does not have symptoms follow appropriate CDC guidance for home isolation.

Maintain healthy operations (Steps 1–3)

- Implement flexible sick leave policies and practices, if feasible.
- Monitor staff absenteeism and have a roster of trained back-up staff.
- Monitor health clinic traffic. School nurses and other healthcare providers play an important role in monitoring health clinic traffic and the types of illnesses and symptoms among students.
- Designate a staff person to be responsible for responding to COVID-19 concerns. Employees should know who this person is and how to contact them.
- Create a communication system for staff and families for self-reporting of symptoms and notification of exposures and closures.
- Support coping and resilience among employees and children.

Closing

Steps 1–3

- Check state and local health department notices daily about transmission in the area and adjust operations accordingly.
- In the event a person diagnosed with COVID-19 is determined to have been in the building and poses a risk to the community, programs may consider closing for a short time (1–2 days) for cleaning and disinfection.

INTERIM GUIDANCE FOR EMPLOYERS WITH WORKERS AT HIGH RISK

As workplaces consider a gradual scale up of activities towards pre-COVID-19 operating practices, it is particularly important to keep in mind that some workers are at higher risk for severe illness from COVID-19. These workers include individuals over age 65 and those with underlying medical conditions. Such underlying conditions include, but are not limited to, chronic lung disease, moderate to severe asthma, hypertension, severe heart conditions, weakened immunity, severe obesity, diabetes, liver disease, and chronic kidney disease that requires dialysis. Workers at higher risk for severe illness should be encouraged to self-identify, and employers should avoid making unnecessary medical inquiries. Employers should take particular care to reduce workers' risk of exposure to COVID-19, while making sure to be compliant with relevant Americans with Disabilities Act (ADA) and Age Discrimination in Employment Act (ADEA) regulations. First and foremost, this means following CDC and the Occupational Safety and Health Administration (OSHA) guidance for reducing workplace exposure for all employees. All decisions about following these recommendations should be made in collaboration with local health officials and other state and local authorities who can help assess the current level of mitigation needed based on levels of COVID-19 community transmission and the capacities of the local public health and healthcare systems. In addition, the guidance offered below applies to workplaces generally; specific industries may require more stringent safety precautions. Finally, there may be essential workplaces in which the recommended mitigation strategies are not feasible. CDC is releasing this interim guidance, laid out in a series of three steps, to inform a gradual scale up of operations. The scope and nature of community mitigation suggested decreases from Step 1 to Step 3. Some amount of community mitigation is necessary across all steps until a vaccine or therapeutic drug becomes widely available.

Scaling Up Operations

- **In all Steps:**
  - » Establish and maintain communication with local and state authorities to determine current mitigation levels in your community.
  - » Protect employees at higher risk for severe illness by supporting and encouraging options to telework.
  - » Consider offering workers at higher risk duties that minimize their contact with customers and other employees (e.g., restocking shelves rather than working as a cashier), if agreed to by the worker.
  - » Encourage any other entities sharing the same work space also follow this guidance.
  - » Provide employees from higher transmission areas (earlier Step areas) telework and other options as feasible to eliminate travel to workplaces in lower transmission (later Step) areas and vice versa.
- **Step 1:** Scale up only if business can ensure strict social distancing, proper cleaning and disinfecting requirements, and protection of their workers and customers; workers at higher risk for severe illness are recommended to shelter in place.
- **Step 2:** Scale up only if business can ensure moderate social distancing, proper cleaning and disinfecting requirements, and protection of their workers and customers; workers at higher risk for severe illness are recommended to shelter in place.
- **Step 3:** Scale up only if business can ensure limited social distancing, proper cleaning and disinfecting requirements, and protection of their workers and customers.

Safety Action

Promote healthy hygiene practices (Steps 1–3)

- Enforce hand washing, covering coughs and sneezes, and using cloth face coverings when around others where feasible;
- however, certain industries may require face shields.
- Ensure that adequate supplies to support healthy hygiene behaviors, including soap, hand sanitizer with at least 60 percent alcohol, tissues, paper towels, and no-touch trash cans.
- Post signs on how to stop the spread of COVID-19 properly wash hands, promote everyday protective measures, and properly wear a face covering.

Intensify cleaning, disinfection, and ventilation (Steps 1–3)

- Clean and disinfect frequently touched surfaces at least daily and shared objects between use.
- Avoid use or sharing of items that are not easily cleaned, sanitized, or disinfected.
- Ensure safe and correct application of disinfectants.
- Ensure that ventilation systems operate properly and increase circulation of outdoor air as much as possible such as by opening windows and doors. Do not open windows and doors if doing so poses a safety risk to individuals and employees using the workspace.
- Take steps to ensure that all water systems and features (for example, drinking fountains, decorative fountains) are safe to use after a prolonged facility shutdown to minimize the risk of Legionnaires' disease and other diseases associated with water.

Promote social distancing (Steps 1–3)

- Limit service to drive-throughs, curbside take out, or delivery options, if possible (Step 1).
- Consider installing physical barriers, such as sneeze guards and partitions, and changing workspace layouts to ensure all individuals remain at least 6 feet apart.
- Close communal spaces, such as break rooms, if possible (Step 1) or stagger use and clean and disinfect in between uses (Steps 2 & 3).
- Encourage telework for as many employees as possible.
- Consider rotating or staggering shifts to limit the number of employees in the workplace at the same time.
- Replace in-person meetings with video- or tele-conference calls whenever possible.
- Cancel all group events, gatherings, or meetings of more than 10 people (Step 1), of more than 50 people (Step 2), and any events where social distancing of at least 6 feet cannot be maintained between participants (all Steps).
- Restrict (Step 1) or consider limiting (Step 2) any nonessential visitors, volunteers, and activities involving external groups or organizations.
- Limit any sharing of foods, tools, equipment, or supplies.

Limit travel and modify commuting practices (Steps 1–3)

- Cancel all non-essential travel (Step 1) and consider resuming non-essential travel in accordance with state and local regulations and guidance (Steps 2 & 3).

- Ask employees who use public transportation to consider using teleworking to promote social distancing.
- Train all managers and staff in the above safety actions. Consider conducting the training virtually, or if in-person, ensure that social distancing is maintained.

Monitoring and Preparing

Checking for signs and symptoms (Steps 1–3)

- Consider conducting routine, daily health checks (e.g., temperature and symptom screening) of all employees.
- If implementing health checks, conduct them safely and respectfully, and in accordance with any applicable privacy laws and regulations. Confidentiality should be respected. Employers may use examples of screening methods in CDC's General Business FAQs as a guide.
- Encourage employees who are sick to stay at home.

Plan for when an employee becomes sick (Steps 1–3)

- Employees with symptoms (fever, cough, or shortness of breath) at work should immediately be separated and sent home.
- Establish procedures for safely transporting anyone sick to their home or to a healthcare facility.
- Notify local health officials, staff, and customers (if possible) immediately of a possible case while maintaining confidentiality consistent with the Americans with Disabilities Act (ADA) and other applicable federal and state privacy laws.
- Close off areas used by the sick person until after cleaning and disinfection Wait 24 hours to clean and disinfect. If it is not possible to wait 24 hours, wait as long as possible before cleaning and disinfecting. Ensure safe and correct application of disinfectants and keep disinfectant products away from children.
- Inform those who have had close contact to a person diagnosed with COVID-19 to stay home and self-monitor for symptoms, and to follow CDC guidance if symptoms develop. If a person does not have symptoms follow appropriate CDC guidance for home isolation.
- Sick employees should not return to work until they have met CDC's criteria to discontinue home isolation.

Maintain healthy operations (Steps 1–3)

- Implement flexible sick leave and other flexible policies and practices, such as telework, if feasible.
- Monitor absenteeism of employees and create a roster of trained back-up staff.
- Designate a staff person to be responsible for responding to COVID-19 concerns. Employees should know who this person is and how to contact them.
- Create and test communication systems for employees for self-reporting and notification of exposures and closures.
- Support coping and resilience among employees.

Closing

Steps 1–3

- Check state and local health department notices daily about transmission in the area and adjust operations accordingly.
- Be prepared to consider closing for a few days if there is a case of COVID-19 in the workplace or for longer if cases increase in the local area.

INTERIM GUIDANCE FOR RESTAURANTS AND BARS

This guidance provides considerations for businesses in the food service industry (e.g., restaurants and bars) on ways to maintain healthy business operations and a safe and healthy work environment for employees, while reducing the risk of COVID-19 spread for both employees and customers. Employers should follow applicable Occupational Safety and Health Administration (OSHA) and CDC guidance for businesses to plan and respond to COVID-19. All decisions about implementing these recommendations should be made in collaboration with local health officials and other state and local authorities who can help assess the current level of mitigation needed based on levels of COVID-19 community transmission and the capacities of the local public health and healthcare systems. CDC is releasing this interim guidance, laid out in a series of three steps, to inform a gradual scale up of activities towards pre-COVID-19 operating practices. The scope and nature of community mitigation suggested decreases from Step 1 to Step 3. Some amount of community mitigation is necessary across all steps until a vaccine or therapeutic drug becomes widely available.

Scaling Up Operations

- **In all Steps:**
  - » Establish and maintain communication with local and state authorities to determine current mitigation levels in your community.
  - » Consider assigning workers at high risk for severe illness duties that minimize their contact with customers and other employees (e.g., managing inventory rather than working as a cashier, managing administrative needs through telework).
  - » Provide employees from higher transmission areas (earlier Step areas) telework and other options as feasible to eliminate travel to workplaces in lower transmission (later Step) areas and vice versa.
- **Step 1:** Bars remain closed and restaurant service should remain limited to drive-through, curbside take out, or delivery with strict social distancing.
- **Step 2:** Bars may open with limited capacity; restaurants may open dining rooms with limited seating capacity that allows for social distancing.
- **Step 3:** Bars may open with increased standing room occupancy that allows for social distancing; restaurants may operate while maintaining social distancing.

Safety Actions

Promote healthy hygiene practices (Steps 1–3)

- Enforce hand washing, covering coughs and sneezes, and use of a cloth face coverings by employees when near other employees and customers.
- Ensure adequate supplies to support healthy hygiene practices for both employees and customers including soap, hand sanitizer with at least 60 percent alcohol (on every table, if supplies allow), paper towels, and tissues.
- Post signs on how to stop the spread of COVID-19 properly wash hands, promote everyday protective measures, and properly wear a face covering.

Intensify cleaning, disinfection, and ventilation (Steps 1–3)

- Clean and disinfect frequently touched surfaces (for example, door handles, workstations, cash registers) at least daily and shared objects (for example, payment terminals, tables, countertops/bars, receipt trays, condiment holders) between use. Use products that meet EPA's criteria for use against SARS-CoV-2 and that

are appropriate for the surface. Prior to wiping the surface, allow the disinfectant to sit for the necessary contact time recommended by the manufacturer. Train staff on proper cleaning procedures to ensure safe and correct application of disinfectants.

- Make available individual disinfectant wipes in bathrooms.
- Wash, rinse, and sanitize food contact surfaces, food preparation surfaces, and beverage equipment after use.
- Avoid using or sharing items such as menus, condiments, and any other food. Instead, use disposable or digital menus, single serving condiments, and no-touch trash cans and doors.
- Use touchless payment options as much as possible, when available. Ask customers and employees to exchange cash or card payments by placing on a receipt tray or on the counter rather than by hand. Clean and disinfect any pens, counters, or hard surfaces between use or customer.
- Use disposable food service items (utensils, dishes). If disposable items are not feasible, ensure that all non-disposable food service items are handled with gloves and washed with dish soap and hot water or in a dishwasher. Employees should wash their hands after removing their gloves or after directly handling used food service items
- Use gloves when removing garbage bags or handling and disposing of trash and wash hands afterwards
- Avoid using food and beverage containers or utensils brought in by customers.
- Ensure that ventilation systems operate properly and increase circulation of outdoor air as much as possible such as by opening windows and doors. Do not open windows and doors if doing so poses a safety risk to employees, children, or customers.
- Take steps to ensure that all water systems and features (for example, drinking fountains, decorative fountains) are safe to use after a prolonged facility shutdown to minimize the risk of Legionnaires' disease and other diseases associated with water.

Promote social distancing

Step 1

- Limit service to drive-through, delivery, or curb-side pick-up options only.
- Provide physical guides, such as tape on floors or sidewalks to ensure that customers remain at least 6 feet apart in lines or ask customers to wait in their cars or away from the establishment while waiting to pick up food. Post signs to inform customers of food pickup protocols.
- Consider installing physical barriers, such as sneeze guards and partitions at cash registers, or other food pickup areas where maintaining physical distance of 6 feet is difficult.
- Restrict the number of employees in shared spaces, including kitchens, break rooms, and offices to maintain at least a six-foot distance between people.
- Rotate or stagger shifts to limit the number of employees in the workplace at the same time.

Step 2

- Provide drive-through, delivery, or curb-side pick-up options and prioritize outdoor seating as much as possible.
- Reduce occupancy and limit the size of parties dining in together to sizes that ensure that all customer parties remain at least 6 feet apart (e.g., all tables and bar stools 6 feet apart, marking tables/stools that are not for use) in order to protect staff and other guests.

- Provide physical guides, such as tape on floors or sidewalks and signage on walls to ensure that customers remain at least 6 feet apart in lines or waiting for seating.
- Ask customers to wait in their cars or away from the establishment while waiting to be seated. If possible, use phone app technology to alert patrons when their table is ready to avoid touching and use of "buzzers."
- Consider options for dine-in customers to order ahead of time to limit the amount of time spent in the establishment.
- Avoid offering any self-serve food or drink options, such as buffets, salad bars, and drink stations.
- Install physical barriers, such as sneeze guards and partitions at cash registers, bars, host stands, and other areas where maintaining physical distance of 6 feet is difficult.
- Limit the number of employees in shared spaces, including kitchens, break rooms, and offices to maintain at least a six-foot distance between people.

Step 3

- Provide drive-through, delivery, or curbside pick-up options and prioritize outdoor seating as much as possible.
- Consider reducing occupancy and limiting the size of parties dining in together to sizes that ensure that all customer parties remain at least 6 feet apart (e.g., all tables and bar stools 6 feet apart, marking tables/stools that are not for use) in order to protect staff and other guests.
- Provide physical guides, such as tape on floors or sidewalks and signage on walls, to ensure that customers remain at least 6 feet apart in lines or waiting for seating.
- If possible, use phone app technology to alert patrons when their table is ready to avoid touching and use of "buzzers."
- Consider options for dine-in customers to order ahead of time to limit the amount of time spent in the establishment.
- Avoid offering any self-serve food or drink options, such as buffets, salad bars, and drink stations.
- Install physical barriers, such as sneeze guards and partitions at cash registers, bars, host stands, and other areas where maintaining physical distance of 6 feet is difficult.

Train all staff (Steps 1–3)

- Train all employees in the above safety actions while maintaining social distancing and use of face coverings during training.

Monitoring and Preparing

Checking for signs and symptoms (Steps 1–3)

- Consider conducting daily health checks (e.g., temperature and symptom screening) of employees.
- If implementing health checks, conduct them safely and respectfully, and in accordance with any applicable privacy laws and regulations. Confidentiality should be respected. Employers may use examples of screening methods in CDC's General Business FAQs as a guide.
- Encourage staff who are sick to stay at home.

Plan for when an employee becomes sick (Steps 1–3)

- Employees with symptoms of COVID-19 (fever, cough, or shortness of breath) at work should immediately be sent to their home.
- Inform those who have had close contact to a person diagnosed with COVID-19 to stay home and self-monitor for symptoms, and to follow CDC guidance if symptoms develop. If a person does not have symptoms follow appropriate CDC guidance for home isolation.
- Establish procedures for safely transporting anyone sick to their home or to a healthcare facility.
- Notify local health officials, staff, and customers (if possible) immediately of any possible case of COVID-19 while maintaining confidentiality consistent with the Americans with Disabilities Act (ADA) and other applicable federal and state privacy laws.
- Close off areas used by a sick person and do not sure them until after cleaning and disinfection. Wait 24 hours before cleaning and disinfecting. If it is not possible to wait 24 hours, wait as long as possible. Ensure safe and correct application of disinfectants and keep disinfectant products away from children.
- Advise sick staff members not to return until they have met CDC's criteria to discontinue home isolation.

Maintain healthy operations (Steps 1–3)

- Implement flexible sick leave and other flexible policies and practices, such as telework, if feasible.
- Monitor absenteeism of employees and create a roster of trained back-up staff.
- Designate a staff person to be responsible for responding to COVID-19 concerns. Employees should know who this person is and how to contact them.
- Create and test communication systems for employees for self-reporting and notification of exposures and closures.
- Support coping and resilience among employees.

Closing

Steps 1–3

- Check state and local health department notices about transmission in the area daily and adjust operations accordingly.
- Be prepared to consider closing for a few days if there is a case of COVID-19 in the establishment and for longer if cases increase in the local area.

INTERIM GUIDANCE FOR MASS TRANSIT ADMINISTRATORS

Mass transit is critical for many Americans to commute to and from work and to access essential goods and services. This guidance provides considerations for mass transit administrators to maintain healthy business operations and a safe and healthy work environment for employees, while reducing the risk of COVID-19 spread for both employees and passengers. Administrators should follow applicable guidance from the CDC and Occupational Safety and Health Administration (OSHA) for reducing workplace exposure. All decisions about following these recommendations should be made in collaboration with local health officials and other state and local authorities who can help assess the current level of mitigation needed based on levels of

COVID-19 community transmission and the capacities of the local public health and healthcare systems. CDC is releasing this interim guidance, laid out in a series of three steps, to inform a gradual scale up of activities towards pre-COVID-19 operating practices. The scope and nature of community mitigation suggested decreases from Step 1 to Step 3. Some amount of community mitigation is necessary across all steps until a vaccine or therapeutic drug becomes widely available.

Resuming Full Service

- **In all Steps:**
  - » Adjust routes between areas experiencing different levels of transmission (between areas in different Steps), to the extent possible.
  - » Provide employees from higher transmission areas (earlier Step areas) telework and other options as feasible to eliminate travel to workplaces in lower transmission (later Step) areas and vice versa.
  - » Establish and maintain communication with state and local health officials to determine current mitigation levels in the communities served. Decisions about how and when to resume full service should be based on these levels.
  - » Follow CDC's guidance on what bus transit operators, rail transit operators, transit maintenance workers, and transit station workers need to know about COVID-19.
  - » Consider assigning workers at high risk of severe illness duties that minimize their contact with passengers and other employees
  - » Conduct worksite hazard assessments to identify COVID-19 prevention strategies, such as appropriate use of cloth face coverings or personal protective equipment (PPE), and follow the prevention strategies.
- **Step 1:** Restrict ridership to essential critical infrastructure workers in areas needing significant mitigation and maintain strict social distancing as much as possible.
- **Step 2:** Maintain social distancing between transit riders and employees as much as possible.
- **Step 3:** Encourage social distancing as much as possible.

Safety Actions

Promote healthy hygiene practices (Steps 1–3)

- Enforce everyday preventive actions such as hand washing, covering coughs and sneezes, and use of a cloth face covering by employees when around others, as safety permits. Provide employees with appropriate personal protective equipment as necessary and as available. Communicate with the public about the importance of hygiene, covering coughs and sneezes, and using cloth face coverings while using mass transportations, including posting signs in transit stations and vehicles on how to stop the spread of COVID-19, properly wash hands, promote everyday protective measures, and properly wear a face covering.

- Ensure adequate supplies to support healthy hygiene behaviors for transit operators, employees, and passengers in stations, including soap, hand sanitizer with at least 60 percent alcohol, paper towels, tissues, and no-touch trash cans.
- Post signs on how to stop the spread of COVID-19 properly wash hands, promote everyday protective measures, and properly wear a face covering.

Intensify cleaning, disinfection, and ventilation (Steps 1–3)

- Clean and disinfect frequently touched surfaces (for example, kiosks, digital interfaces such as touchscreens and fingerprint scanners, ticket machines, turnstiles, handrails, restroom surfaces, elevator buttons) at least daily or between use as feasible.
- Clean and disinfect the operator area between operator shifts.
- Use touchless payment and no-touch trash cans and doors as much as possible, when available. Ask customers and employees to exchange cash or credit cards by placing in a receipt tray or on the counter rather than by hand and wipe any pens, counters, or hard surfaces between each use or customer.
- Avoid using or sharing items that are not easily cleaned, sanitized, or disinfected, such as disposable transit maps.
- Ensure safe and correct application of disinfectants.
- Use gloves when removing garbage bags or handling and disposing of trash and wash hands afterwards.
- Ensure that ventilation systems operate properly and increase circulation of outdoor air as much as possible such as by opening windows and doors. Do not open windows and doors if they pose a safety risk to passengers or employees, or other vulnerable individuals.
- Take steps to ensure that all water systems and features (for example, drinking fountains, decorative fountains) are safe to use after a prolonged facility shutdown to minimize the risk of Legionnaires' disease and other diseases associated with water.

Promote social distancing

Step 1 and Step 2

- Institute measures to physically separate or create distance of at least 6 feet between all occupants to the extent possible. This may include:
  - » Asking bus passengers to enter and exit the bus through rear doors, while allowing exceptions for persons with disabilities.
  - » Closing every other row of seats.
  - » Reducing maximum occupancy of buses and individual subway and train cars and increasing service on crowded routes as appropriate.
- Provide physical guides to ensure that customers remain at least 6 feet apart while on vehicles and at transit stations and stops. For example, floor decals, colored tape, or signs to indicate where passengers should not sit or stand can be used to guide passengers.
- Install physical barriers, such as sneeze guards and partitions at staffed kiosks and on transit vehicles to the extent practicable.
- Close communal spaces, such as break rooms, if possible; otherwise, stagger use and clean and disinfect in between uses.

Step 3

- Consider or continue instituting measures to physically separate or create distance between occupants.
- Provide physical guides to help customers maintain physical distance while on vehicles and at transit stations and stops. For example, floor decals, colored tape, or signs to indicate where passengers should not sit or stand can be used to guide passengers.
- Install or maintain physical barriers, such as sneeze guards and partitions at staffed kiosks and on transit vehicles to the extent practicable.

Train employees (Steps 1–3)

- Train all employees in the above safety actions while maintaining social distancing during training.

Monitoring and Preparing

Checking for signs and symptoms (Steps 1–3)

- Consider conducting daily health checks (e.g., temperature screening and/or symptom checking) of all employees.
- If implementing health checks, conduct them safely and respectfully, and in accordance with any applicable privacy laws and regulations. Confidentiality should be respected. Employers may use examples of screening methods in CDC's General Business FAQs as a guide.
- Encourage staff who are sick to stay at home.

Plan for when an employee becomes sick (Steps 1–3)

- Employees with symptoms of COVID-19 (fever, cough, or shortness of breath) at work should immediately be sent home.
- Inform those who have had close contact to a person diagnosed with COVID-19 to stay home and self-monitor for symptoms, and to follow CDC guidance if symptoms develop. If a person does not have symptoms follow appropriate CDC guidance for home isolation.
- Establish procedures for safely transporting anyone sick to their home or to a healthcare facility.
- Notify local health officials, staff, and customers (if possible) immediately of any possible case of COVID-19 while maintaining confidentiality consistent with the Americans with Disabilities Act (ADA) and other applicable federal and state privacy laws.
- Close off areas used by a sick person and do not use until after cleaning and disinfection. Wait 24 hours before cleaning and disinfecting. If 24 hours is not feasible, wait as long as possible. Ensure safe and correct application of disinfectants and keep disinfectant products away from children. Affected vehicles can be used immediately after cleaning and disinfection.
- Advise sick staff members not to return until they have met CDC's criteria to discontinue home isolation.
- Implement safety practices for critical infrastructure workers who may have had exposure to a person with suspected or confirmed COVID-19.

Maintain healthy operations (Steps 1–3)

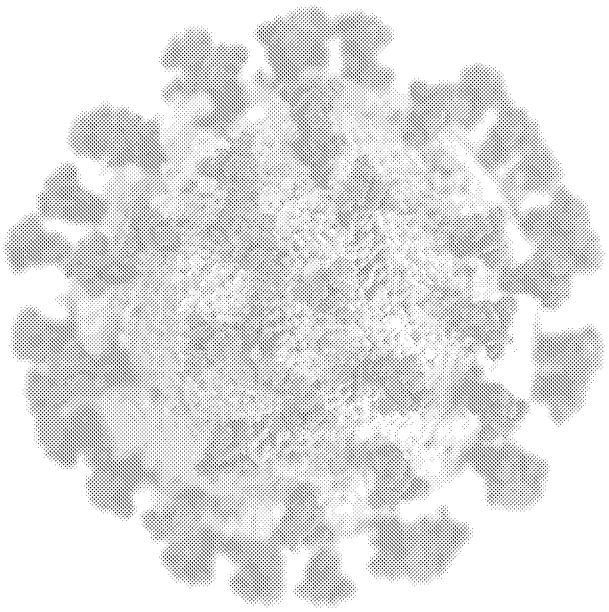
- Implement flexible sick leave and other flexible policies and practices, if feasible.
- Monitor absenteeism of employees and create a roster of trained back-up staff.

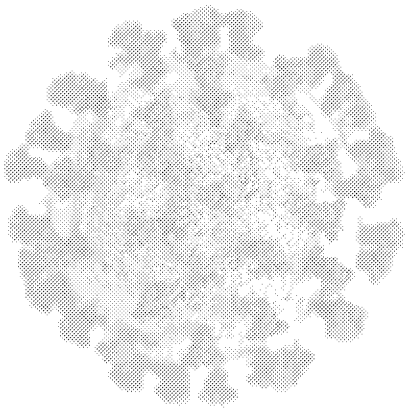
- Designate a staff person to be responsible for responding to COVID-19 concerns. Employees and customers should know who this person is and how to contact them.
- Create and test communication systems for employees and customers for self-reporting of symptoms and notification of exposures and closures.
- Support coping and resilience among employees.

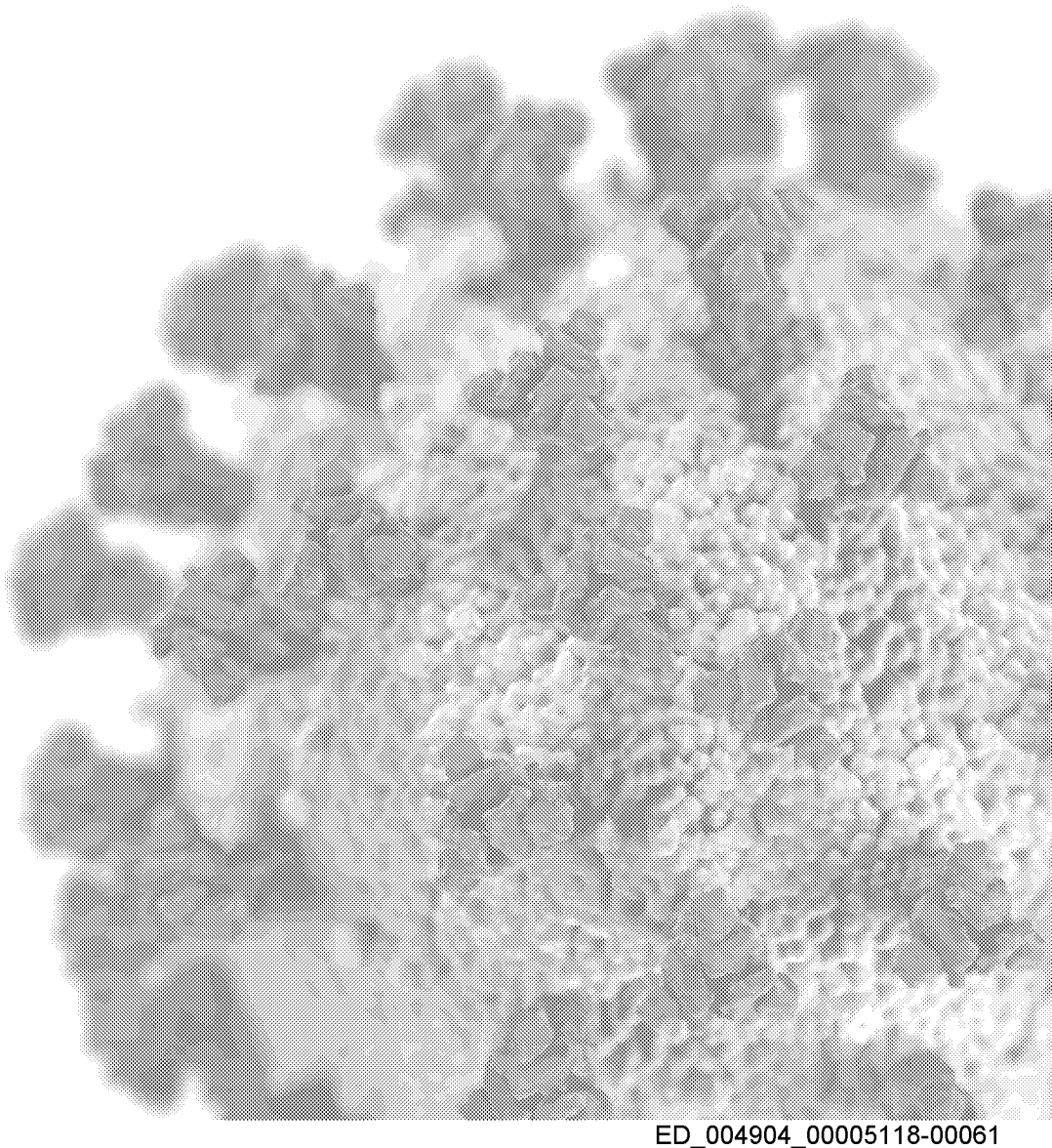
Adjusting Service

Steps 1–3

- Coordinate with state and local health department officials about transmission in the area as frequently as possible and adjust operations accordingly.
- Be prepared to consider adjusting services as appropriate if the community mitigation level increases in the local area.
- Continue communication with staff and the public about decision-making.



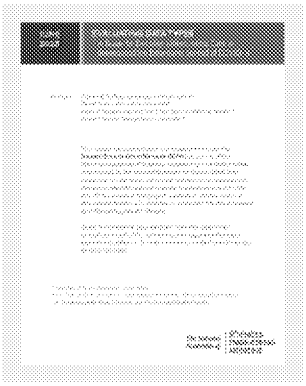




cdc.gov/coronavirus

U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

CS317670-A June 16, 2020 2:25 PM



Evaluating Data Types: A Guide for Decision Makers using Data to Understand the Extent and Spread of COVID-19 (2020)

DETAILS

15 pages | 8.5 x 11 | PDF
ISBN 978-0-309-67858-2 | DOI 10.17226/25826

CONTRIBUTORS

National Academies of Sciences, Engineering, and Medicine

SUGGESTED CITATION

National Academies of Sciences, Engineering, and Medicine 2020. *Evaluating Data Types: A Guide for Decision Makers using Data to Understand the Extent and Spread of COVID-19*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25826.

JUNE 2020

EVALUATING DATA TYPES

A Guide for Decision Makers using Data to Understand the Extent and Spread of COVID-19

Authors: Adrian E. Raftery, University of Washington*
Janet Currie, Princeton University*
Mary T. Bassett, Harvard T.H. Chan School of Public Health**
Robert Groves, Georgetown University**

This rapid expert consultation was produced through the **Societal Experts Action Network (SEAN)**, an activity of the National Academies of Sciences, Engineering, and Medicine that is sponsored by the National Science Foundation. SEAN links researchers in the social, behavioral, and economic sciences with decision makers to respond to policy questions arising from the COVID-19 pandemic. This project is affiliated with the National Academies' Standing Committee on Emerging Infectious Diseases and 21st Century Health Threats.

SEAN is interested in your feedback. Was this rapid expert consultation useful? For further inquiries regarding this rapid expert consultation or to send comments, contact sean@nas.edu or (202) 334-3440.

*Member of SEAN Executive Committee
**Co-Chair of SEAN Executive Committee and Member of Standing Committee on Emerging Infectious Diseases and 21st Century Health Threats

The National Academies of SCIENCES ENGINEERING MEDICINE

EXECUTIVE SUMMARY

This rapid expert consultation was produced by the Societal Experts Action Network (SEAN), a project of the National Academies of Sciences, Engineering, and Medicine with support from the National Science Foundation. Its aim is to enable leaders such as you to gain insight into the strengths and weaknesses of the data on the COVID-19 pandemic in your community by applying five criteria to seven types of data available to support decision making. **By understanding these characteristics, you can work with the data type best-suited to the question at hand, and use the data you have to inform your decisions most effectively.**

The seven data types are: the number of confirmed cases, hospitalizations, emergency department visits, reported confirmed COVID-19 deaths, excess deaths, fraction of viral tests that are positive, and representative prevalence surveys (including both viral and antibody tests). The five criteria are: representativeness; bias; uncertainty, and measurement and sampling error; time; and space. The importance of any of these five criteria depends on the nature of the decision being made, and each data type has different strengths and weaknesses.

Each data type represents a piece of the puzzle, and when used in combination, the various types form a clearer picture of how the disease is spreading and its severity. Because any single data type is likely to yield an under- or over- estimate of the extent and spread of the disease, it is important to consider multiple data types and be cautious in relying on estimates without considering sources of bias. The key implications for decision makers are summarized in Box 1 below.

BOX 1
KEY IMPLICATIONS FOR DECISION MAKERS

Confirmed Cases: This measure is readily available, but is likely to be an underestimate of total persons with the disease. As the volume of testing expands, this measure should be more useful.

Hospitalizations: These data are typically available quickly, but reflect only the most severe cases of infection and patients who were exposed to the virus several weeks before admission.

Emergency Department Visits: Data on visits may be available at the local level in close to real time and are most useful in the early stages of an outbreak or to assess resurgence, though it is important to remember that patients with symptoms were exposed up to 2 weeks earlier.

Reported Confirmed COVID-19 Deaths: These data reflect the state of the outbreak several weeks previously because of the long course of infection.

Excess Deaths: Compared with the other data reviewed, excess deaths are the best indicator of the mortality impacts of the pandemic. Excess deaths also reflect the state of the outbreak several weeks previously given the long course of infection.

Fraction of Viral Tests That Are Positive: These data may not be an adequate measure of prevalence, depending on testing criteria. If mainly symptomatic people are tested, these data are expected to overestimate the true community prevalence. The proportion of positive tests is expected to decline as testing expands to include mildly symptomatic and asymptomatic people.

Representative Prevalence Surveys: Data from these surveys represent the best strategy for understanding the prevalence of a disease in any given population (workplace, nursing home, etc.) at a specific point in time.

INTRODUCTION

Fortunately, more information about how COVID-19 is affecting the nation is now available, but as is so often the case, the information comes in various forms and is not always complete. The purpose of this rapid expert consultation is to help decision makers, especially at state and local levels, better understand and evaluate the strengths and limitations of the various data types being used as indicators of the extent and spread of COVID-19 in their communities. This enhanced understanding can lead to more informed decisions on critical issues that depend on those indicators, such as when to lift social distancing restrictions, allow public gatherings, or reopen businesses. Drawing on relevant literature and expert judgment, this rapid expert consultation describes the considerations that apply in using the available data while taking account of their limitations. It reviews in turn:

1. Seven data types used as indicators for evaluating the course of COVID-19 in a community or population
2. Five criteria against which the reliability and validity of these data types can be assessed
3. Cautions to consider in making decisions with imperfect data
4. Specific limitations and cautions that apply to data on COVID-19

This rapid expert consultation addresses the assessment of the seven data types and the implications of those assessments for decision making; it does not recommend specific policy actions.

Specific features of the disease and response to the pandemic have implications for understanding this assessment of data types. According to the Centers for Disease Control and Prevention (CDC) (2020a), the incubation period for COVID-19 is thought to be up to 14 days, with a median time of 4–5 days from exposure to onset of symptoms and with deaths indicating infection from several weeks previously. This long incubation period and progression of infection, as well as the possibility of asymptomatic cases, has implications, discussed below, for interpreting the different data types. Also, determining both the prevalence of COVID-19 and deaths from the disease depends on the availability and accuracy of testing. In the early days of the pandemic, viral tests were rationed, and it was difficult for people to get tested. Viral tests have become more widely available, but are still available mainly to people with symptoms. Antibody tests have also become more widely available, but are of variable quality. The utility of antibody tests depends on the sensitivity and specificity of the assays, and current testing at this point could result in relatively more false-positive and fewer false-negative results.[1] Some demographic groups, such as the elderly, African Americans, Latinos, and Native Americans, have been disproportionately affected by the virus, suggesting that data for these groups may deserve particular attention. Data collection should include relevant information to allow examination of such disparities, which at present is frequently missing.

[1]According to the CDC (2020), evidence "suggests that the presence of antibodies may decrease a person's infectiousness and offer some level of protection from reinfection. However, definitive data are lacking, and it remains uncertain whether individuals with antibodies (neutralizing or total) are protected against reinfection with SARS-CoV-2, and if so, what concentration of antibodies is needed to confer protection….pending additional data, the presence of antibodies cannot be equated with an individual's immunity from SARS-CoV-2 infection." Moreover, "the utility of tests depends on the sensitivity and specificity of the assays....In most of the country, including areas that have been heavily impacted, the prevalence of SARS-CoV-2 antibody is expected to be low, ranging from <5% to 25%, so that testing at this point might result in relatively more false-positive results and fewer false-negative results." See https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antibody-tests-guidelines.html.

1. DATA TYPES USED TO EVALUATE THE COURSE OF COVID-19

The following types of data on the extent and spread of COVID-19, some of which are highly correlated with each other, are being used to inform decision making:

- **Number of confirmed cases** (positives from diagnostic/viral tests) as indicators of total COVID-19 cases
- **Hospitalizations** (and ICU beds occupied) as a measure of strain on the hospital system and the numbers of severe cases
- **Emergency department visits** as a measure of patient-initiated care seeking and numbers of people with similar syndromes, such as influenza-like illnesses, which can be an indicator of clinically important COVID-19–type illness
- **Reported confirmed COVID-19 deaths** as the basis for estimating deaths associated with COVID-19
- **Excess deaths** (all causes) over prior comparable time periods as a measure of the total number of deaths that may be directly or indirectly attributable to COVID-19
- **Fraction of viral tests that are positive** as a measure of the total number of currently infected persons
- **Representative prevalence surveys** (including both viral and antibody tests) administered to a representative sample of a defined population to estimate the percentage of persons in that population either currently or formerly positive for COVID-19

Given the rapid evolution of understanding of the virus that causes COVID-19, additional data types are emerging. For instance, surveillance of wastewater to detect the virus that causes COVID-19 could provide information to communities about the virus's reemergence, and some researchers are using cell phone data to track compliance with social distancing guidelines.

2. CRITERIA FOR ASSESSING THE RELIABILITY AND VALIDITY OF THE DATA TYPES

The utility of data for decision making is affected by many factors, including the burden of collecting, cleaning, and interpreting the data across sources. Also, data collection and models tend to improve over time, so their assessment will also need to be updated regularly.[2] Meanwhile, decision makers must use the data that are available while understanding their limitations. To this end, the following five criteria can be considered:

- **Representativeness:** Does the reporting population represent the population of interest? Does each person in the population have an equal chance of being measured?
- **Bias:** Are there systematic factors that could cause the values reported to be overestimates or underestimates of the actual values? Is there a difference between what is reported and what one wants to measure?
- **Uncertainty, and Measurement and Sampling Error:** Is there uncertainty due to small sample sizes; that is, do small sample sizes cause unstable numbers? Have people been measured twice? Do tests produce accurate results?
- **Time:** What is the time lag in reporting the numbers? Are the numbers consistently updated, or are there time gaps in delivery of the data? Do time lags differ across sources? Has the

[2]This document does not specifically review models, but the data types reviewed are typically the inputs to models. Thus, understanding the characteristics of the data inputs can inform understanding of models and similar forecasting tools related to the course of the pandemic.

nature of measurement changed over time in a way that impacts reported estimates? Are events recorded on the day they occurred or the day they were reported?

- **Space:** Do the numbers cover all geographic areas of interest? Are areas of particular interest covered? Do all areas use the same measurement and classification system? Do the indicators count persons outside the given jurisdiction?

Table 1 shows the seven data types listed above against the five criteria for assessing their reliability and validity. Check marks indicate that a data type generally meets a criterion, while the triangles denote the need for caution, meaning that the questions listed above under a criterion should be asked to better understand the quality of the data.

3. MAKING DECISIONS WITH IMPERFECT DATA: CAUTIONS TO CONSIDER

Decisions must be made in critical situations even when there is uncertainty about the best available data. It is important for decision makers to be aware of the strengths and weaknesses of the data they receive. This requires that a decision maker rely on the data available to the extent that they promote better decision making, while being mindful of the following cautions:

- **Small case counts:** Counts based on small numbers of cases tend to be unstable and of limited utility for decision making.
- **Time lag between the occurrence of an indicator and its reporting:** Data tend to become more complete over time, so that counts must generally be revised (e.g., deaths on weekends are often reported on the next working day). A second problem is that data on deaths, for example, reflect infections that occurred some time ago and thus need to be interpreted in that context.
- **Overestimation and underestimation:** Given two indicators, one of which may result from systematic overestimation and the other from systematic underestimation, it is good to use both to guide a decision. For example, the proportion of positive tests in a sample of people with active symptoms will be an overestimate of the true prevalence of disease in the population, while the number of confirmed cases as a proportion of the population will likely be an underestimate.
- **Disproportionate impact:** Because averages can obscure disproportionate impacts, using averages as the basis for decisions may affect some individuals in the relevant population more than others. In view of the disproportionate impact of COVID-19 on some groups, it is important to consider the numbers for specific groups based on age, location, race/ethnicity, socioeconomic status, and other factors.
- **Importance of qualitative data:** Quantitative data may provide a limited picture of a situation. Thus in some cases, qualitative (non-numerical) data can be a valuable supplement. Before such data are used, however, it is important to consider how representative they are, just as one would do with quantitative data.
- **Transparency:** Ensuring the open availability of data improves transparency and accountability. It is important to share data with the public and to develop feedback mechanisms so that communities can be engaged to inform responses to the data.

Table 1: Assessment of Data Types by Criteria for Reliability and Validity

	Representativeness	Bias	Uncertainty, Measurement & Sampling Error	Time	Space
Number of confirmed cases	⚠	⚠	☑	⚠	⚠
Key Implication for Decision Making: This measure is readily available, but is likely to be a substantial underestimate of the prevalence of the disease in a population given that most people with COVID-19 are asymptomatic, and even among those who are symptomatic, not all are tested. As the volume of testing expands to include populations with less severe symptoms and asymptomatic individuals, this measure will be increasingly useful for determining the prevalence of COVID-19.					
Hospitalizations	⚠	⚠	☑	⚠	⚠
Key Implication for Decision Making: Data on hospitalizations are typically available quickly at the local level, although the completeness of reporting may vary from day to day. These data reflect only the most severe cases of infection, but changes in the number of hospitalizations likely reflect similar changes in the total number of infections within a community. Note patients requiring hospitalization were exposed several weeks previously.					
Emergency department visits	⚠	⚠	☑	⚠	⚠
Key Implication for Decision Making: In some jurisdictions, data on emergency department (ED) visits are available at the local level in close to real time. The reason for the visit can be reported either as a syndrome (e.g., "influenza-like illness") or as a specific diagnosis (e.g., "COVID-19"). These data are most useful in the early stages of an outbreak or to assess resurgence, though it should be noted that patients with symptoms were exposed up to 2 weeks earlier.					
Reported deaths	⚠	⚠	⚠	⚠	⚠
Key Implication for Decision Making: Reported COVID-19 deaths are affected by the accuracy of cause-of-death determinations and reflect the state of the outbreak several weeks previously because of the long course of COVID-19 infection. Sometimes lags in reporting of data also occur.					
Excess deaths	☑	⚠	☑	☑	☑
Key Implication for Decision Making: Compared with the other data reviewed here, excess deaths are the best indicator of the mortality impacts of the pandemic. However, because of the possibility of death misclassification, these data represent a mix of confirmed COVID-19 deaths and deaths from other causes.					
Fraction of viral tests that are positive	⚠	⚠	⚠	⚠	⚠
Key Implication for Decision Making: These data may not be an adequate measure of prevalence, depending on testing criteria. If mainly symptomatic people are tested, this figure is expected to overestimate the true community prevalence. The proportion is expected to decline as testing expands to include mildly symptomatic and asymptomatic people.					
Prevalence surveys (representative)	☑	☑	☑	⚠	☑
Key Implication for Decision Making: Representative prevalence surveys are the best strategy for understanding the prevalence of a disease in any given population at a specific point in time. Such surveys can be undertaken for specific populations (e.g., workplace, nursing home, jails and prisons). Although they require undertaking a special study rather than using routinely collected data, many public health agencies have this capacity. There will be some time lag involved, however, in mounting and interpreting such a survey.					

☑ Data source usually meets this criterion.

⚠ Data source may or may not meet the criterion, and questions related to that criterion should be asked.

4. SPECIFIC LIMITATIONS AND CAUTIONS REGARDING COVID-19 DATA

This section applies the five criteria described in section 2 to the seven data types commonly used to make COVID-19 policy decisions as outlined in section 1. Decision makers should use the data available to them, as they represent some of the best indicators currently available, while being explicit about their limitations and highlighting questions that should be asked of those providing the data.

Number of Confirmed Cases

Implications for decision making: This measure is readily available, but is likely to be a substantial underestimate of the prevalence of the disease in a population given that most people with COVID-19 are asymptomatic, and even among those who are symptomatic, not all are tested. As the volume of testing expands to include populations with less severe symptoms and asymptomatic individuals, this measure will be increasingly useful for determining the prevalence of COVID-19.

- **Representativeness:** The number of confirmed cases per 1,000 people per week, month, or year (i.e., the rate of confirmed cases) is not representative of actual prevalence in the population because of limited testing capacity and the widespread lack of testing of asymptomatic individuals. The reported number is likely to be a substantial underestimate of infected persons by a factor of as much as 10 or more, although this factor is likely to decline over time as testing becomes more widespread (Bedford et al., 2020; Johndrow et al., 2020).
- **Bias:** The number of confirmed cases is an underestimate because in addition to the limitations of testing noted above, many people lack access to testing and are less likely to seek it out, and only those with sufficiently severe symptoms are tested. This may be a particular problem for those who lack health insurance, who live in underresourced relative to more affluent areas, or who may avoid seeking testing because of fear (e.g., undocumented immigrants) (Borjas, 2020). An additional problem arises if testing is more intensive in virus hot spots. Well-done surveys of representative samples of people can help in understanding the magnitude of this problem. Contact tracing and testing may also be helpful in identifying previously unconfirmed cases.
- **Uncertainty, and measurement and sampling error:** Sampling error due to small numbers of cases is likely to be a much smaller problem than bias. If multiple positive tests are reported for the same person over time, the number of positive tests divided by the base population could possibly produce an overestimate of the actual number of cases.
- **Time:** Confirmed cases are usually reported daily, but these reports contain consistent errors, such as underreporting on weekends, and it may take several days for test results to be confirmed. The underestimation of prevalence is likely to be consistent over short time periods, and so the trend in confirmed cases can be a good indicator of short-term trends in prevalence. However, there are problems of comparability over longer time scales, because the extent of underestimation tends to decline over time as more people are tested.
- **Space:** Confirmed cases tend to be reported by hospitals or other official testing sites and thus should be available at a fine-grained geographic scale. However, the bias in confirmed cases and rates of testing may differ among different areas, so these data may not be comparable across space. In addition, some localities include suspected cases and some do not. Accounting for what is being reported, different testing strategies or types of tests, and cases in which people seek treatment in counties where they do not reside may help explain some of these differences, thus making comparisons more useful.

Hospitalizations

Implications for decision making: Data on hospitalizations are typically available quickly at the local level, although the completeness of reporting may vary from day to day. These data reflect only the most severe cases of infection, but short-term changes in the number of hospitalizations

likely reflect similar changes in the total number of infections within a community. Note that patients requiring hospitalization were exposed several weeks previously.

- **Representativeness:** Data on current hospitalizations tend to be relatively complete, and thus representative of the *hospitalized population* of COVID-19 patients given that people hospitalized with COVID-19 symptoms are much more likely to be tested than the general public. Eventually, all hospital discharges are reported to state authorities. Of course, there are still disparities in access to care, even hospitalization, based on race/ethnicity, nativity, and socioeconomic status (Azar et al., 2020).
- **Bias:** Underestimates may arise from the misdiagnosis of patients with COVID-19, which occurred early in the epidemic and may still be occurring, but less often.[3] For example, some patients diagnosed with pneumonia may actually have COVID-19. However, diagnosis is improving over time.
- **Uncertainty, and measurement and sampling error:** There is relatively little sampling error in this measure, apart from the misdiagnosis bias just mentioned.
- **Time:** As noted, hospitalizations are usually reported in a relatively timely manner, although they may not be reported every day, and aggregation of data from individual hospitals can be unsystematic. The data are likely to be consistent over the relatively short periods of time that are important for decision making. However, they may not be consistent over longer time periods because of the previously discussed potential for misdiagnosis of patients early on in the pandemic. Changes may also have occurred over time in the severity of patients being admitted and lengths of stay, which may depend, for instance, on how crowded a hospital is.
- **Space:** There may be differences across space in the severity of patients being admitted to hospitals. Moreover, the way illnesses are diagnosed and coded varies from hospital to hospital and across cities and states and over time. In areas where hospitals have reached capacity, it is important to track transfers to other hospitals, especially from areas with limited facilities.

Emergency Department Visits

Implications for decision making: In some jurisdictions, data on emergency department (ED) visits are available at the local level in close to real time. The reason for the visit can be reported either as a syndrome (e.g., "influenza-like illness") or as a specific diagnosis (e.g., "COVID-19") (Henning, 2004). These data are most useful in the early stages of an outbreak or to assess resurgence, though it should be noted that patients with symptoms were exposed up to 2 weeks earlier.

- **Representativeness:** Most EDs report visit data, and nearly 75 percent of ED visits nationally are captured by the National Syndromic Surveillance System (Hartnett et al., 2020). These data reflect those who use EDs for their health care needs. Depending on local availability of and barriers to accessing both primary and ED care, specific groups may be either under- or overrepresented in ED visit data. Consideration should be given to data representativeness by such characteristics as race/ethnicity, income, and nativity. However, those with the most severe disease may seek care in the ED regardless of these considerations.
- **Bias:** Diagnoses made in the ED may be modified subsequently and may underestimate or overestimate actual COVID-19 cases, especially given time lags in processing of tests. Diagnoses of syndromes, such as "influenza like illness," are based on International Classification of Diseases (ICD) coding, which may be incomplete at any given time or may be driven by considerations of reimbursement or other nonclinical factors.

[3]It is of course possible that overestimation could occur, as would be the case if someone who is positive for COVID-19 has been hospitalized for a different reason (e.g., heart attack). Multiple factors contribute to a person's state of health, and there may be some differentiation in how hospitals classify the reason for hospitalization. That said, the potential for such overestimation is less concerning than the underestimation described above in terms of assessing public health risks.

- **Uncertainty, and measurement and sampling error:** There is relatively little sampling error in this measure as it is a fairly complete count of visits in most jurisdictions, apart from the problem of provisional diagnoses noted above. In some cases, data on ED visits may be combined with data on hospitalizations to give a count of people using a facility in a particular period. In this case, care should be taken to account for possible double counting of patients who appeared in the ED and were hospitalized later. Given uncertainty about diagnosis and the possibility that many people with such syndromes as "influenza-like illness" do not have COVID-19, it may be useful to compare these data with data from prior years.
- **Time:** As with hospitalizations, a key advantage of ED visit data is their availability and relative timeliness at the local level, though it will take longer for the data to be transmitted to national databases. Such syndromes as "influenza-like illness" are not specific diagnoses, and all ED diagnoses are provisional. Users of data on time trends should consider that there may be improvement in diagnosis over time.
- **Space:** As in the case of hospitalizations, using data on ED visits to draw inferences about differences in COVID-19 prevalence across places is unlikely to be possible. The extent to which the local population utilizes the ED is likely to vary with population characteristics, as discussed above. Moreover, the way illnesses are diagnosed and coded varies from hospital to hospital and across cities and states, as well as over time.

Reported Deaths

Implications for decision making: Reported COVID-19 deaths are affected by the accuracy of cause-of-death determinations and reflect the state of the outbreak several weeks ago because of the long course of COVID-19 infection. Sometimes lags in reporting of data also occur.

- **Representativeness:** Reported deaths from COVID-19 are likely to be an underestimate because of underdiagnosis, as well as variations in testing across locations. The underestimate may be substantial, and will depend in part on whether "probable" deaths as well as deaths "confirmed" via a test are included. For example, Washington State officials estimate that the number of actual COVID-19 deaths in that state may have been three times greater than the reported number because of the lack of testing early in the epidemic (Bellisle, 2020). Moreover, patients who died from another underlying condition (e.g., heart failure) may be misclassified as COVID-19 deaths, biasing estimates upward.
- **Bias:** As noted, reported deaths from COVID-19 are likely to be underestimates, although some positive bias in the case of patients who were already severely ill is possible (see above).
- **Uncertainty, and measurement and sampling error:** There is little sampling error in this indicator. Measurement issues arise from misdiagnosis or uncertainty about true causes of death. Also, race/ethnicity may be misreported or incomplete on death certificates, especially for American Indian/Alaska Native populations (Arias et al., 2016), leading to errors in calculated death rates by race and ethnicity.
- **Time:** Local health authorities initially report deaths quickly, but the final, complete, cleaned data may take time to produce. The quality of diagnosis may be improving over time, leading to inconsistency, particularly between the early and later periods of the pandemic.
- **Space:** All jurisdictions report deaths, but if misdiagnosis varies among areas, then comparability across areas could be compromised. Note that a similar issue occurs with respect to hospitalizations, so the same caveat applies to both sources of data.

Excess Deaths

Implications for decision making: Compared with the other data reviewed here, excess deaths are the best indicator of the mortality impacts of the pandemic. However, because of the possibility of death misclassification noted above, these data represent a mix of confirmed COVID-19 deaths and deaths from other causes. For example, from March 11-May 2, 2020, New York City reported

13,831 confirmed and 5,048 probable COIVD-19 deaths. Additionally, there were a further 5,293 excess deaths that might have been directly or indirectly attributable to the pandemic (Centers for Disease Control and Prevention, 2020b). The percentages of these deaths that occurred in persons infected with COVID-19 or that resulted from indirect impacts of the pandemic are unknown and require further investigation.

- **Representativeness:** Since all deaths are counted, and each decedent's age, gender, residence, and race/ethnicity are known, these are likely the most representative data available other than those from representative prevalence surveys. As noted above, however, race/ethnicity may be misreported or incomplete on death certificates, leading to errors in death rates by race and ethnicity (Arias et al., 2016).
- **Bias:** The main potential source of bias is selection of a comparison period that itself is unrepresentative. This source of bias can be mitigated by using an average of the past several years as a comparison. Also, it is important to keep in mind that the number of excess deaths will be affected by COVID-19 deaths; deaths from other causes that may have been exacerbated by the response to the pandemic (e.g., when patients delayed seeking care because of concerns about contracting COVID-19 at the hospital, or suicides or domestic violence deaths associated with lockdowns increased); and deaths (e.g., due to traffic accidents) that were prevented by lockdowns. A second type of bias that should be considered is related to underlying changes in population composition, due, for instance, to migration or changes in the age structure. Changes in population composition over time, especially at the county level, may affect trends in excess deaths. These underlying trends should be considered when assessing and adjusting data on excess deaths.
- **Uncertainty, and measurement and sampling error:** There will always be some uncertainty about excess deaths. While the total number of deaths is reasonably accurate, it is difficult to calculate "excess deaths" because deaths in each year reflect unique public health phenomena. As a result, computing excess deaths is a statistical procedure that entails comparing current deaths with expected deaths based on historical averages, and the magnitude of the excess will depend on the time period chosen for comparison.
- **Time:** Given data on the number of deaths, excess deaths can be computed in a timely way relative to past numbers of deaths in the same week or month of the year in most local jurisdictions. It takes longer for deaths to be transmitted to states and the federal government. Data on excess deaths are likely to be the most complete data available because they do not depend on accuracy of diagnosis of COVID-19. Hence, these data will also be the most comparable over time. As with reported deaths, however, the final, complete data on deaths, and therefore on excess deaths, may take time to produce.
- **Space:** These data will be complete and comparable across space.

Fraction of Viral Tests That Are Positive

Implications for decision making: These data may not be an adequate measure of prevalence, depending on testing criteria. If mainly symptomatic people are tested, these data are expected to overestimate the true community prevalence. The proportion is expected to decline as testing expands to include mildly symptomatic and asymptomatic people. *Note: Understanding of the accuracy of antibody testing and its utility as an indicator of immunity is still evolving (reference footnote 1 in the introduction).*

- **Representativeness:** The extent to which these data meet this criterion will depend on the extent to which the people tested are representative of the population. Currently, many tests are administered to people who are referred by their doctors or who feel that they may have COVID-19, and the testing may occur in either public or private facilities. The positivity rate among people with symptoms is likely to be biased upward because this population is unrepresentative, consisting of people who are, on average, more likely to have the disease

relative to those without symptoms. If the people tested are not representative of the population, then as the volume of testing increases, the percentage of positive viral tests can be expected to decline even if the true prevalence of the disease in the population remains constant. Thus the fraction of tests that are positive reflects both the prevalence of the disease and the extent of testing and is not separately a reliable measure of either. However, the fraction of positive tests will decline as testing expands to people who are mildly ill or asymptomatic.[4]

- **Bias:** Tests are usually imperfect, and treating them as if they are perfect can lead to large biases. In general, the observed prevalence, or positivity rate, can be misleading unless the test employed is of high quality. The quality of tests is measured by two numbers: sensitivity, or the proportion of people who have the disease and test positive for it (the true positive rate); and specificity, or the proportion of healthy people that test negative (the true negative rate). With a perfect test, both of these numbers would be 100 percent.[5]
- **Uncertainty, and measurement and sampling error:** Both false positives and false negatives can occur. The quality of tests with respect to this criterion is measured by the sensitivity and specificity of the test. When the prevalence of COVID-19 is low, the likelihood that a positive test predicts disease will decline.
- **Time:** Comparability across time may be poor unless (1) the sample of people tested is representative of the population, and (2) the test results are adjusted for sensitivity and specificity, as described above.
- **Space:** Comparability across space may also be poor unless the sample is representative and the test results are adjusted. Indeed, it may be worse than comparability across time because the differences in sensitivity and specificity across different testing sites may be considerable.

Representative Prevalence Surveys

For these surveys, a representative sample of people to be tested is selected. The World Health Organization (WHO) has produced a protocol for such surveys for COVID-19 (World Health Organization, 2020). Dean (2020) outlines the advantages and challenges of such surveys, as well as ways to make the most of them. Such surveys can be conducted at the local, state, or national level. Oregon, Indiana, and Ohio have initiated such efforts. Similar surveys are often carried out for social science or market research as well as epidemiological purposes, so the methodology is well established. Several such surveys have been conducted to capture the prevalence of COVID-19, including the COVID-19 Impact Survey that is administering symptom checkers to known representative samples in 18 subnational areas (Wozniak et al., 2020; Vogel, 2020; Joseph and Branswell, 2020).

Implications for decision making: Representative prevalence surveys are the best strategy for understanding the prevalence of a disease in any given population at a specific point in time. Such surveys can be undertaken for specific populations (e.g., workplace, nursing home, jails and prisons). Although they require undertaking a special study rather than using routinely collected data, many public health agencies have this capacity. There will be some time lag involved, however, in mounting and interpreting such a survey. While prevalence surveys in general, such as surveys of health care workers or convenience samples (defined in footnote 7 below) of grocery shoppers, may be useful if replicated over time to measure trends, they are not necessarily representative.

- **Representativeness:** These surveys are representative by design, thus avoiding the lack of representativeness that characterizes many current prevalence estimates based on tests.

---

[4]See also http://freerangestats.info/blog/2020/05/09/covid-population-incidence.

[5]If the test is not perfect, the observed prevalence can be adjusted as follows: Adjusted prevalence = (Observed prevalence + Specificity – 1)/(Sensitivity + Specificity – 1) (Rogan and Gladen, 1978).

Representativeness is usually ensured by taking a random sample, whereas prevalence surveys using convenience samples[7] will generally not be representative.[8] The same problem with lack of representativeness is true of samples consisting of volunteers.

- **Bias:** If prevalence surveys are based on representative samples and if the sensitivity and specificity of the viral tests are known, bias due to errors in the tests can be corrected using well-known statistical formulas. It is important to make these corrections so that unbiased estimates can be obtained; see footnote 1 (Biemer and Lyberg, 2008).
- **Uncertainty, and measurement and sampling error:** If a survey is representative, these data deficiencies can be quantified. However, sampling error can be substantial in small random samples. Also, uncertainty in a prevalence survey will not be well quantified if the survey is not designed to be representative, as when, for example, convenience samples or volunteers are used.
- **Time:** This criterion depends on how quickly the results of a survey can be produced and how often the survey is carried out. If it is not carried out frequently, the results may still be useful to adjust for biases in other data types. For example, data from the American Community Survey are often used to see how representative a given sample may be in terms of the distribution of such demographic characteristics as age, sex, and race.
- **Space:** Spatial completeness is good as long as a representative sample is used, but this may not be the case with convenience samples or volunteer subjects.

CONCLUSION

The COVID-19 pandemic is a reminder, once again, of the importance of evidence and a robust public health data infrastructure. Decision making related to the pandemic requires the use of data often not designed for the task at hand. With greater understanding of the strengths and limitations of these data, decision makers can make better decisions. Continued investment in public health and its data surveillance structures is needed to meet the nation's current and future public health challenges.

SEAN is interested in your feedback. Was this rapid expert consultation useful? Send comments to sean@nas.edu or (202) 334-3440.

[7]Convenience samples are constructed from a group of people that are easy to contact or reach, and are not random.

[8]For prevalence surveys, it is sometimes possible to use proxies for representative samples. For instance, in March and April 2020, seroprevalence surveys of health care workers in many major medical centers did not do a bad job of anticipating the local area prevalence. Health care workers are at higher occupational risk, but they are also more affluent than average, so those biases cancelled each other out somewhat. Another example might be a large heterogenous employer in a city that had all its employees tested; this might not be a bad proxy for a truly representative sample for that city.

REFERENCES

Arias, E., Heron, M., and Hakes, J.K. (2016). The validity of race and Hispanic-origin reporting on death certificates in the United States: An update. *Vital and Health Statistics* 2(172), 1-21. Available: https://www.researchgate.net/publication/306079754_The_Validity_of_Race_and_Hispanic-origin_Reporting_on_Death_Certificates_in_the_United_States_An_Update.

Azar, K., Shen, Z., Romanelli, R., Lockhart, S., Smits, K., Robinson, S., Brown, S., and Pressman, A. (2020). Disparities in outcomes among COVID-19 patients in a large health care system in California. *Health Affairs*, 39(7), 1-8.

Bedford, T., Greninger, A.L., Roychoudhury, P., Starita, L.M., Famulare, M., et al. (2020). *Cryptic transmission of SARS-CoV2 in Washington State.* MedRxiv Preprint. Available: https://www.medrxiv.org/content/medrxiv/early/2020/04/16/2020.04.02.20051417.full.pdf.

Bellisle, M. (2020). Washington State's actual coronavirus death toll may be higher than current tallies, health officials say. *Seattle Times*. May 21. Available: https://www.seattletimes.com/seattle-news/health/washington-states-actual-coronavirus-death-toll-may-be-higher-than-current-tallies-health-officials-say.

Biemer, P., and Lyberg, L. (2008). *Introduction to Survey Quality*. New York: Wiley Interscience.

Borjas, G.J. (2020). Demographic determinants of testing incidence and COVID-19 infection in New York City neighborhoods. *NBER Working Paper 26952.* April. Available: https://www.nber.org/papers/w26952.pdf.

Centers for Disease Control and Prevention. (2020a). *Interim clinical guidelines for management of patients with confirmed coronavirus disease (COVID-19).* Available: https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

_____. (2020b). Preliminary estimate of excess mortality during the COVID-19 outbreak—New York City, March 11–May 2, 2020. *Morbidity and Mortality Weekly Report,* 69(19), 603-605.

Dean, N.E. (2020). COVID-19 data dives: The takeaways from seroprevalence surveys. *Medscape*. May 4. Available: https://www.medscape.com/viewarticle/929861.

Henning, K.J. (2004). What is syndromic surveillance? Syndromic Surveillance: Reports from a National Conference, 2003. *Morbidity and Mortality Weekly Report*, 53 (Suppl):7-11.

Hartnett, K.P., Kite-Powell, A., DeVies, J., Coletta, M.A., Boehmer, T.K., Adjemian, J., Gundlapalli, A.V. (2020). Impact of the COVID-19 pandemic on emergency department visits—United States, January 1, 2019–May 30, 2020. *Morbidity and Mortality Weekly Report*, June 3, 2020, early release, 69.

Johndrow, J., Lum, K., Gargiulo, M. and Ball, P. (2020). Estimating the number of SARS-CoV-2 infections and the impact of social distancing in the United States. *arXiv Preprint*. Available: https://arxiv.org/pdf/2004.02605v2.pdf.

Joseph, A., and Branswell, H. (2020). The results of coronavirus 'serosurveys' are starting to be released. Here's how to kick their tires. *STAT,* April 24. Available: https://www.statnews.com/2020/04/24/the-results-of-coronavirus-serosurveys-are-starting-to-be-released-heres-how-to-kick-their-tires.

Rogan, W.J., and Gladen, B. (1978). Estimating prevalence from the results of a screening test. *American Journal of Epidemiology*, 107(1), 71-76. Available: https://pubmed.ncbi.nlm.nih.gov/623091.

Vogel, G. (2020). Antibody surveys suggesting vast undercount of coronavirus infections may be unreliable. *Science,* April 21. Available: https://www.sciencemag.org/news/2020/04/antibody-surveys-suggesting-vast-undercount-coronavirus-infections-may-be-unreliable.

World Health Organization. (2020). *Population-based age-stratified seroepidemiological investigation protocol for COVID-19 virus infection*. Available: https://apps.who.int/iris/handle/10665/331656.

Wozniak, A., Willey, J., Benz, J., and Hart, N. (2020) *COVID Impact Survey.* Chicago, IL: National Opinion Research Center.

ACKNOWLEDGMENTS

Special thanks go to our colleagues on the SEAN executive committee, who dedicated time and thought to this project: Dominique Brossard, University of Wisconsin, Madison; Michael Hout, New York University; Arati Prabhakar, Actuate; and Jennifer Richeson, Yale University.

We extend gratitude to the staff of the National Academies of Sciences, Engineering, and Medicine, in particular to Emily P. Backes, who contributed research, editing, and writing assistance. Thanks are also due to Mike Stebbins (Science Advisors, LLC and Federation of American Scientists) and Kerry Duggan (SustainabiliD, LLC and Federation of American Scientists), consultants to SEAN, who provided additional editorial and writing assistance. We also thank Rona Briere for her skillful editing.

To supplement their own expertise, the authors received input from several external sources, whose willingness to share their perspectives and expertise was essential to this work. We thank Oxiris Barbot, New York City Department Health and Mental Hygiene; Paul Biemer, RTI International and University of North Carolina, Chapel Hill; Ron Carlee, Old Dominion University; Jeffrey Eaton, Imperial College London; Thomas Farley, Philadelphia Department of Public Health; William Hanage, Harvard T.H. Chan School of Public Health; Stéphane Helleringer, The Johns Hopkins University; Claude-Alix Jacob, Cambridge Public Health Department; Nancy Krieger, Harvard T.H. Chan School of Public Health; Roger J. Lewis, Harbor-UCLA Medical Center; Linda Langston, Langston Strategies Group; Roderick Little, University of Michigan; Christopher J. L. Murray, University of Washington; Annise Parker, Victory Fund and Victory Institute; and John Shirey, City of Sacramento (retired).

We also thank the following individuals for their review of this rapid expert consultation: Georges C. Benjamin, American Public Health Association; Nicholas A. Christakis, Yale University; Ana Diez-Roux, Drexel University; David Dowdy, Johns Hopkins University; Adriana Lleras-Muney, University of California, Los Angeles; Abigail Wozniak, Federal Reserve Bank of Minneapolis; Emilio Zagheni, Max Planck Institute for Demographic Research.

Although the reviewers listed above provided many constructive comments and suggestions, they were not asked to endorse the conclusions of this document, nor did they see the final draft before its release. The review of this document was overseen by Susan J. Curry, The University of Iowa and Alicia L. Carriquiry, Iowa State University. They were responsible for making certain that an independent examination of this rapid expert consultation was carried out in accordance with the standards of the National Academies and that all review comments were carefully considered. Responsibility for the final content rests entirely with the authors and the National Academies.

SOCIETAL EXPERTS ACTION NETWORK (SEAN) EXECUTIVE COMMITTEE

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

People of Any Age with Underlying Medical Conditions

Summary of Recent Changes

Revisions were made on June 25, 2020 to reflect available data as of May 29, 2020. We are learning more about COVID-19 every day, and as new information becomes available, CDC will update the information below.

People of any age with **certain underlying medical conditions** are at increased risk for severe illness from COVID-19:

People of any age with the following conditions **are at increased risk** of severe illness from COVID-19:

- Chronic kidney disease
- COPD (chronic obstructive pulmonary disease)
- Immunocompromised state (weakened immune system) from solid organ transplant
- Obesity (body mass index [BMI] of 30 or higher)
- Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
- Sickle cell disease
- Type 2 diabetes mellitus

Children who are medically complex, who have neurologic, genetic, metabolic conditions, or who have congenital heart disease are at higher risk for severe illness from COVID-19 than other children.

COVID-19 is a new disease. Currently there are limited data and information about the impact of underlying medical conditions and whether they increase the risk for severe illness from COVID-19. Based on what we know at this time, people with the following conditions **might be at an increased risk** for severe illness from COVID-19:

- Asthma (moderate-to-severe)
- Cerebrovascular disease (affects blood vessels and blood supply to the brain)
- Cystic fibrosis
- Hypertension or high blood pressure
- Immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines
- Neurologic conditions, such as dementia
- Liver disease
- Pregnancy
- Pulmonary fibrosis (having damaged or scarred lung tissues)
- Smoking
- Thalassemia (a type of blood disorder)
- Type 1 diabetes mellitus

Want to see the evidence behind these lists?

The list of underlying conditions is meant to inform clinicians to help them provide the best care possible for patients, and to inform individuals as to what their level of risk may be so they can make individual decisions about illness prevention. We are learning more about COVID-19 every day. This list is a living document that may be updated at any time, subject to potentially rapid change as the science evolves.

Reduce your risk of getting COVID-19

It is especially important for people at increased risk of severe illness from COVID-19, and those who live with them, to protect themselves from getting COVID-19.

The best way to protect yourself and to help reduce the spread of the virus that causes COVID-19 is to:

- Limit your interactions with other people as much as possible.
- Take precautions to prevent getting COVID-19 when you do interact with others.

If you start feeling sick and think you may have COVID-19, get in touch with your healthcare provider within 24 hours.

Venturing out into a public setting? What to consider before you go.

As communities and businesses across the United States are opening, you may be thinking about resuming some activities, running errands, and attending events and gatherings. **There is no way to ensure you have zero risk of infection,** so it is important to understand the risks and know how to be as safe as possible.

People at increased risk of severe illness from COVID-19, and those who live with them, should consider their level of risk before deciding to go out and ensure they are taking steps to protect themselves. Consider avoiding activities where taking protective measures may be difficult, such as activities where social distancing can't be maintained. **Everyone should take steps to prevent getting and spreading COVID-19** to protect themselves, their communities, and people who are at increased risk of severe illness.

In general, **the more people you interact with, the more closely you interact with them, and the longer that interaction, the higher your risk of getting and spreading COVID-19.**

- If you decide to engage in public activities, continue to protect yourself by practicing everyday preventive actions.
- Keep these items on hand and use them when venturing out: a cloth face covering, tissues, and a hand sanitizer with at least 60% alcohol, if possible.
- If possible, avoid others who are not wearing cloth face coverings or ask others around you to wear cloth face coverings.

Are you considering in-person visits with family and friends? Here are some things to consider to help make your visit as safe as possible:

When to delay or cancel a visit

- Delay or cancel a visit if you or your visitors have symptoms of COVID-19 or have been exposed to someone with COVID-19 in the last 14 days.
- Anyone who has had close contact with a person with COVID-19 should stay home and monitor for symptoms.

In general, the more people you interact with, the more closely you interact with them, and the longer that interaction, the higher the risk of COVID-19 spread. So, think about:

- How many people will you interact with?
- Can you keep 6 feet of space between you and others?
- Will you be outdoors or indoors?
- What's the length of time that you will be interacting with people?

Encourage social distancing during your visit

- Visit with your friends and family **outdoors**, when possible. If this is not feasible, make sure the room or space is well-ventilated (for example, open windows or doors) and large enough to accommodate social distancing.

- Arrange tables and chairs to allow for social distancing. People from the same household can be in groups together and don't need to be 6 feet apart from each other.
- Consider activities where social distancing can be maintained, like sidewalk chalk art or yard games.
- Try to avoid close contact with your visitors. For example, don't shake hands, elbow bump, or hug. Instead wave and verbally greet them.
- If possible, avoid others who are not wearing cloth face coverings or ask others around you to wear cloth face coverings.
- Consider keeping a list of people you visited or who visited you and when the visit occurred. This will help with contract tracing if someone becomes sick.

Wear cloth face coverings

- Cloth face coverings should be worn over the nose and mouth. Cloth face coverings are especially important when it is difficult to stay at least 6 feet apart from others or when people are indoors to help protect each other.
- Cloth face coverings may slow the spread of the virus and help people who may have the virus and do not know it from transmitting it to others
  - Wearing a cloth face covering helps protects others in case you're infected, while others wear one to protect you should they be infected.
- **Who should NOT use cloth face coverings**: Children under age 2 or anyone who has trouble breathing, is unconscious, or is incapacitated or otherwise unable to remove the mask without assistance.

Wash hands often

- Everyone should wash their hands for at least 20 seconds at the beginning and end of the visit and whenever you think your hands may have become contaminated.
- If soap and water are not readily available, such as with outdoor visits or activities, use a hand sanitizer that contains at least 60% alcohol. Cover all surfaces of your hands and rub them together until they feel dry.
- Remind guests to wash or sanitize their hands before serving or eating food.
- Use single-use hand towels or paper towels for drying hands so visitors do not share towels. Have a no-touch trash can available for guests to use.

Limit contact with commonly touched surfaces or shared items

- Encourage your visitors to bring their own food and drinks.
- Clean and disinfect commonly touched surfaces and any shared items between use.
- If you choose to use any shared items that are reusable (e.g., seating covers, tablecloths, linen napkins), wash, clean, and sanitize them after the event.

If you are thinking about participating in an event or gathering:

If you are at increased risk for severe illness, consider avoiding high-risk gatherings. The risk of COVID-19 spreading at events and gatherings increases as follows:

Lowest risk: Virtual-only activities, events, and gatherings.

More risk: Smaller outdoor and in-person gatherings in which individuals from different households remain spaced at least 6 feet apart, wear cloth face coverings, do not share objects, and come from the same local area (e.g., community, town, city, or county).

Higher risk: Medium-sized in-person gatherings that are adapted to allow individuals to remain spaced at least 6 feet apart and with attendees coming from outside the local area.

Highest risk: Large in-person gatherings where it is difficult for individuals to remain spaced at least 6 feet apart and attendees travel from outside the local area.

Stay healthy during the COVID-19 pandemic

Staying healthy during the pandemic is important. Talk to your healthcare provider about whether your vaccinations and other preventive services are up to date to help prevent you from becoming ill with other diseases.

- It is particularly important for those at increased risk of severe illness, including older adults, to receive recommended vaccinations against influenza and pneumococcal disease.
- Remember the importance of staying physically active and practicing healthy habits to cope with stress.

If you have an underlying medical condition, you should continue to follow your treatment plan:

- **Continue your medicines** and do not change your treatment plan without talking to your healthcare provider.
- **Have at least a 30-day supply** of prescription and non-prescription medicines. Talk to a healthcare provider, insurer, and pharmacist about getting an extra supply (i.e., more than 30 days) of prescription medicines, if possible, to reduce your trips to the pharmacy.
- **Do not delay getting emergency care for your underlying medical condition** because of COVID-19. Emergency departments have contingency infection prevention plans to protect you from getting COVID-19 if you need care.
- **Call your healthcare provider if you have any concerns** about your underlying medical conditions or if you get sick and think that you may have COVID-19. If you need emergency help, call 911 right away.
- **If you don't have a healthcare provider,** contact your nearest community health center or health department.

Actions you can take based on your medical conditions and other risk factors

Asthma (moderate-to-severe)

Having moderate-to-severe asthma may increase your risk for severe illness from COVID-19.

Actions to take

- Follow your Asthma Action Plan.
- Keep your asthma under control.
- Continue your current medicines, including any inhalers with steroids in them ("steroids" is another word for corticosteroids).
- Make sure that you have at least a 30-day supply of your medicines.
- Know how to use your inhaler.
- Avoid your asthma triggers.
- Call your healthcare provider if you have concerns about your condition or feel sick.
- **If you don't have a healthcare provider,** contact your nearest community health center or health department.
- If possible, have another member of your household who doesn't have asthma clean and disinfect your house for you. When they use cleaning and disinfecting products, have them:
  - Make sure that people with asthma are not in the room.
  - Minimize use of disinfectants that can cause an asthma attack.
  - Open windows or doors and use a fan that blows air outdoors.
  - Always follow the instructions on the product label.
  - Spray or pour spray products onto a cleaning cloth or paper towel instead of spraying the product directly onto the cleaning surface (if the product label allows).

Learn more about asthma.

Chronic kidney disease

Having chronic kidney disease of any stage increases your risk for severe illness from COVID-19.

Actions to take

- Continue your medicines and your diet as directed by your healthcare provider.
- Make sure that you have at least a 30-day supply of your medicines.
- Stay in contact with your healthcare team as often as possible, especially if you have any new signs or symptoms of illness. Also reach out to them if you can't get the medicines or foods you need.
- **If you don't have a healthcare provider,** contact your nearest community health center or health department.
- Have shelf-stable food choices to help you follow your kidney diet.
- If you are on dialysis:
  - Contact your dialysis clinic and your healthcare provider if you feel sick or have concerns.
  - Do NOT miss your treatments.
  - Plan to have enough food on hand to follow the KCER 3-Day Emergency Diet Plan for dialysis patients in case you are unable to maintain your normal treatment schedule.

Learn more about kidney disease.

Learn how to take care of your kidneys.

COPD, cystic fibrosis, pulmonary fibrosis, and other chronic lung diseases

Having COPD (including emphysema and chronic bronchitis) is known to increase your risk of severe illness from COVID-19. Other chronic lung diseases, such as idiopathic pulmonary fibrosis and cystic fibrosis, may increase your risk of severe illness from COVID-19.

Actions to take

- Keep taking your current medicines, including those with steroids in them ("steroids" is another word for corticosteroids).
- Make sure that you have at least a 30-day supply of your medicines.
- Avoid triggers that make your symptoms worse.
- Call your healthcare provider if you have concerns about your condition or feel sick.
- **If you don't have a healthcare provider,** contact your nearest community health center or health department.

Learn more about COPD.

Diabetes

Having type 2 diabetes increases your risk of severe illness from COVID-19. Based on what we know at this time, having type 1 or gestational diabetes may increase your risk of severe illness from COVID-19.

Actions to take

- Continue taking your diabetes pills and insulin as usual.
- Test your blood sugar and keep track of the results, as directed by your healthcare provider.
- Make sure that you have at least a 30-day supply of your diabetes medicines, including insulin.
- Follow your healthcare provider's instructions if you are feeling ill as well as the sick day tips for people with diabetes.
- Call your healthcare provider if you have concerns about your condition or feel sick.
- **If you don't have a healthcare provider,** contact your nearest community health center or health department.

Learn more about diabetes.

Hemoglobin disorders such as sickle cell disease and thalassemia

Having sickle cell disease (SCD) increases your risk for severe illness from COVID-19. Having other hemoglobin disorders, like thalassemia, may increase your risk for severe illness from COVID-19.

Actions to take

- Ask your healthcare provider about telemedicine or remote healthcare visits, and know when to go to the emergency department.
- Work with your healthcare provider to manage medicines and therapies for your disorder (including hydroxyurea, chelation therapy, blood transfusions, and prescriptions for pain management) and any other health condition you may have (such as diabetes, high blood pressure, and arthritis).
- **If you don't have a healthcare provider,** contact your nearest community health center or health department.
- Try to prevent vaso-occlusive episodes or pain crises by avoiding possible triggers.
- Review CDC's healthy living with SCD guide or our healthy living with thalassemia guide for tips to help you stay healthy.
- Find SCD resources and thalassemia resources to help navigate care and increase knowledge and awareness of SCD and thalassemia.
- Let friends and family know about the need for healthy blood donors.

Immunocompromised state (weakened immune system) from blood, bone marrow, or organ transplant; HIV; use of corticosteroids; or use of other immune weakening medicines

Many conditions and treatments can cause a person to be immunocompromised or have a weakened immune system. These include: having a solid organ transplant, blood, or bone marrow transplant; immune deficiencies; HIV with a low CD4 cell count or not on HIV treatment; prolonged use of corticosteroids; or use of other immune weakening medicines. Having a weakened immune system may increase your risk of severe illness from COVID-19.

Actions to take

- Continue any recommended medicines or treatments and follow the advice of your healthcare provider.
- Do not stop taking your medicines without talking to your healthcare provider.
- Make sure that you have at least a 30-day supply of your medicines.
- Do not delay life-saving treatment or emergency care.
- Call your healthcare provider if you have concerns about your condition or feel sick.
- **If you don't have a healthcare provider,** contact your nearest community health center or health department.

Information for people living with HIV.

Liver disease

Having chronic liver disease, especially cirrhosis (scarring of the liver), may increase your risk for severe illness from COVID-19.

Actions to take

- Take your medicines exactly as prescribed.
- Make sure that you have at least a 30-day supply of your medicines.

- Call your healthcare provider if you have concerns about your condition or feel sick.
- **If you don't have a healthcare provider,** contact your nearest community health center or health department.

Learn more about chronic liver disease.

Pregnancy

Based on what we know at this time, **pregnant people might be at an increased risk for severe illness from COVID-19** compared to non-pregnant people. Additionally, there may be an increased risk of adverse pregnancy outcomes, such as preterm birth, among pregnant people with COVID-19.

Actions to take

- Do not skip your prenatal care appointments.
- Make sure that you have at least a 30-day supply of your medicines.
- Talk to your healthcare provider about how to stay healthy and take care of yourself during the COVID-19 pandemic.
- If you don't have a healthcare provider, contact your nearest community health center or health department.
- Call your healthcare provider if you have any questions related to your health.
- Seek care immediately if you have a medical emergency.
- You may feel increased stress during this pandemic. Fear and anxiety can be overwhelming and cause strong emotions. Learn about stress and coping.

Learn more about pregnancy and COVID-19.

Serious Heart Conditions and Other Cardiovascular and Cerebrovascular Diseases

Having any of the following serious heart conditions increases your risk of severe illness from COVID-19:

- Heart failure
- Coronary artery disease
- Congenital heart disease
- Cardiomyopathies
- Pulmonary hypertension

Having other cardiovascular or cerebrovascular disease, such as hypertension (high blood pressure) or stroke, may increase your risk of severe illness from COVID-19.

Learn more about serious heart conditions

Actions to take

- Take your medicines exactly as prescribed and follow your healthcare provider's recommendations for diet and exercise while maintaining social distancing precautions.
- Continue angiotensin converting enzyme inhibitors (ACE-I) or angiotensin-II receptor blockers (ARB) as prescribed by your healthcare provider for indications such as heart failure or high blood pressure.
- Make sure that you have at least a 30-day supply of your heart disease medicines, including high cholesterol and high blood pressure medicines.
- Call your healthcare provider if you have concerns about your condition or feel sick.
- **If you don't have a healthcare provider,** contact your nearest community health center or health department.
- Do not delay life-saving treatment or emergency care.

Learn more about heart disease.

Learn more about stroke.

Learn more about high blood pressure.

Obesity

Having obesity, defined as a body mass index (BMI) of 30 or above, increases your risk of severe illness from COVID-19.

Actions to take

- Take your medicines for any underlying health conditions exactly as prescribed.
- Follow your healthcare provider's recommendations for nutrition and physical activity, while maintaining social distancing precautions.
- Call your healthcare provider if you have concerns or feel sick.
- **If you don't have a healthcare provider,** contact your nearest community health center or health department.

Learn more about obesity in adults.

Learn about obesity in children.

Neurologic conditions such as dementia

Having neurologic conditions such as dementia may increase your risk of severe illness from COVID-19.

Actions to take

- Take your medicines as prescribed.
- Make sure that you have at least a 30-day supply of your medicines.
- Call your healthcare provider if you have concerns about your condition or feel sick.
- **If you don't have a healthcare provider,** contact your nearest community health center or health department.

Learn more about dementia.

Learn about caring for people living with dementia during COVID-19.

Learn about amyotrophic lateral sclerosis (ALS).

Smoking

Being a current or former cigarette smoker may increase your risk of severe illness from COVID-19.

Actions to take

- If you currently smoke, quit. If you used to smoke, don't start again. If you've never smoked, don't start.
- Counseling from a healthcare provider and Food and Drug Administration (FDA)-approved medications can double

the chances of quitting smoking.

- For help quitting smoking, call 1-800-QUIT-NOW or visit smokefree.gov .
- Call your healthcare provider if you have concerns or feel sick.
- **If you don't have a healthcare provider,** contact your nearest community health center or health department.

Learn about smoking and tobacco use.

Learn about the health effects of cigarette smoking.

Children with Certain Underlying Conditions

While children have been less affected by COVID-19 compared to adults, children with certain conditions may be at increased risk for severe illness. Children who are medically complex, who have serious genetic, neurologic, metabolic disorders, and with congenital (since birth) heart disease may be at increased risk for severe illness from COVID-19. Similar to adults, children with obesity, diabetes, asthma and chronic lung disease, or immunosuppression may be at increased risk for severe illness from COVID-19. CDC is investigating a rare but serious complication associated with COVID-19 in children called Multisystem Inflammatory Syndrome in Children (MIS-C). We do not yet know what causes MIS-C and who is at increased risk for developing it. Learn about MIS-C.

Actions to take

- Give medicines as prescribed for your child's underlying conditions.
- Make sure that you have at least a 30-day supply of your child's medicines.
- Call your child's healthcare provider if you have concerns and to discuss your child's specific conditions and risk for severe illness from COVID-19.
- Well-child visits and vaccines are still important during the COVID-19 pandemic. Stay in contact with your child's healthcare provider and make sure your child is up to date with vaccines to prevent other diseases. Learn more about how to protect yourself and your family during the COVID-19 pandemic.
- **If you don't have a healthcare provider,** contact your nearest community health center or health department.

Learn about preventing illness in your children.

Learn more about congenital heart disease and specific genetic and neurologic disorders in children.

People with Multiple Underlying Conditions

The more underlying medical conditions someone has, the greater their risk is for severe illness from COVID-19.

Actions to take

- Continue your medicines and treatment plans as directed by your healthcare provider.
- Make sure that you have at least a 30-day supply of your medicines.
- Call your healthcare provider if you have any concerns or feel sick.
- **If you don't have a healthcare provider,** contact your nearest community health center or health department.
- Do not delay emergency care.

Page last reviewed: June 25, 2020

Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 7/1/2020 9:20:05 PM
To: Hitchens, Lynnann [hitchens.lynnann@epa.gov]
CC: Castro, Denise [Castro.Denise@epa.gov]
Subject: Re: Question re slight modification to NVFEL reopening plan

Ex. 5 Deliberative Process (DP)

On Jul 1, 2020, at 4:57 PM, Hitchens, Lynnann <hitchens.lynnann@epa.gov> wrote:

Denise –

Ex. 5 Deliberative Process (DP)

Lynnann Hitchens
Acting Deputy Assistant Administrator for
Administration and Resources Management
Office of Mission Support
US EPA
P: 202-564-3184
M: Ex. 6 Personal Privacy (PP)

From: Castro, Denise <Castro.Denise@epa.gov>
Sent: Wednesday, July 1, 2020 2:56 PM
To: Shaw, Betsy <Shaw.Betsy@epa.gov>
Cc: Monroe, Scott <Monroe.Scott@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>
Subject: RE: Question re slight modification to NVFEL reopening plan

HI Betsy,

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP) Thanks!

Sincerely,
Denise Castro, OHR
(202)564-0622; castro.denise@epa.gov

From: Shaw, Betsy <Shaw.Betsy@epa.gov>
Sent: Wednesday, July 1, 2020 11:17 AM
To: Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Castro, Denise <Castro.Denise@epa.gov>
Cc: Monroe, Scott <Monroe.Scott@epa.gov>
Subject: FW: Question re slight modification to NVFEL reopening plan

Hi Lynnann, Nicole and Denise,

Please see proposed change to NVFEL reopening plan in red below and attached. Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Thanks,

Betsy

From: Cook, Leila <cook.leila@epa.gov>
Sent: Wednesday, July 1, 2020 11:10 AM
To: Shaw, Betsy <Shaw.Betsy@epa.gov>
Cc: Dunham, Sarah <Dunham.Sarah@epa.gov>; Schenk, Ruth <schenk.ruth@epa.gov>; Monroe, Scott <Monroe.Scott@epa.gov>; Hengst, Benjamin <Hengst.Benjamin@epa.gov>
Subject: RE: Question re slight modification to NVFEL reopening plan

Hi Betsy,

Here is the slight change highlighted. We just pasted what was in the transmittal note as a fact as of x June 1st date. Draft text is below and revised guidance attached.

Lee
<image001.jpg>

From: Shaw, Betsy <Shaw.Betsy@epa.gov>
Sent: Wednesday, July 1, 2020 8:18 AM
To: Cook, Leila <cook.leila@epa.gov>
Cc: Dunham, Sarah <Dunham.Sarah@epa.gov>; Schenk, Ruth <schenk.ruth@epa.gov>; Monroe, Scott <Monroe.Scott@epa.gov>
Subject: FW: Question re slight modification to NVFEL reopening plan

FYI

From: Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Sent: Wednesday, July 1, 2020 8:06 AM
To: Shaw, Betsy <Shaw.Betsy@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>
Cc: Monroe, Scott <Monroe.Scott@epa.gov>; Castro, Denise <Castro.Denise@epa.gov>
Subject: RE: Question re slight modification to NVFEL reopening plan

Betsy –

Ex. 5 Deliberative Process (DP)

Lynnann Hitchens
Acting Deputy Assistant Administrator for
Administration and Resources Management

Office of Mission Support
US EPA
P: 202-564-3184
M: Ex. 6 Personal Privacy (PP)

From: Shaw, Betsy <Shaw.Betsy@epa.gov>
Sent: Tuesday, June 30, 2020 5:59 PM
To: Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>
Cc: Monroe, Scott <Monroe.Scott@epa.gov>
Subject: FW: Question re slight modification to NVFEL reopening plan

HI again Lynnann and Nicole,

Ex. 5 Deliberative Process (DP)

Thanks,

Betsy

From: Shaw, Betsy
Sent: Tuesday, June 30, 2020 5:54 PM
To: Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>
Cc: Monroe, Scott <Monroe.Scott@epa.gov>
Subject: Question re slight modification to NVFEL reopening plan

Hi Lynnann and Nicole,

Ex. 5 Deliberative Process (DP)

Message

From: Bell, Matthew [Bell.Matthew@epa.gov]
Sent: 6/25/2020 2:32:58 PM
To: Richardson, RobinH [Richardson.RobinH@epa.gov]; Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]; Vizian, Donna [Vizian.Donna@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Cascio, Wayne [Cascio.Wayne@epa.gov]; Baxter, Lisa [Baxter.Lisa@epa.gov]
CC: Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]
Subject: RE: High level summary/Talking Points -- Internal Document/Not for Distribution
Attachments: v2 Phases_06242020 w comments.xlsx

Robin, can you replace the one you just uploaded?

Attached is the revised spreadsheet with the local guidance. I've also double checked that all phases match the master spreadsheet on SP.
I took the liberty of renaming Column R "recommendations" and Column S "Comments". Hopefully that doesn't confuse anyone.

Sincerely,

Matthew Bell
Senior Advisor
Office of Mission Support
U.S. Environmental Protection Agency
(202)564-3282

From: Richardson, RobinH <Richardson.RobinH@epa.gov>
Sent: Thursday, June 25, 2020 10:27 AM
To: Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Cascio, Wayne <Cascio.Wayne@epa.gov>; Baxter, Lisa <Baxter.Lisa@epa.gov>; Bell, Matthew <Bell.Matthew@epa.gov>
Cc: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: High level summary/Talking Points -- Internal Document/Not for Distribution

Matt was going to add the State/Local etc status, and check the Phases and then send back. Would you like the version without those updates? I can save that to the teams site – Covid Collab – would that work?

Robin H Richardson
Deputy Associate Administrator
Office of Congressional and Intergovernmental Relations
U.S. Environmental Protection Agency
202-564-3358 (desk)
Ex. 6 Personal Privacy (PP)
richardson.robinh@epa.gov

From: Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>
Sent: Thursday, June 25, 2020 10:24 AM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Richardson, RobinH <Richardson.RobinH@epa.gov>; Cascio, Wayne <Cascio.Wayne@epa.gov>; Baxter, Lisa <Baxter.Lisa@epa.gov>; Bell, Matthew <Bell.Matthew@epa.gov>
Cc: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: High level summary/Talking Points -- Internal Document/Not for Distribution

I cant see it in teams and don't have a copy

Jennifer Orme-Zavaleta, PhD
Principal Deputy Assistant Administrator for Science
Office of Research and Development
US Environmental Protection Agency

DC 202-564-6620
Ex. 6 Personal Privacy (PP)

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, June 25, 2020 10:23 AM
To: Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>; Richardson, RobinH <Richardson.RobinH@epa.gov>; Cascio, Wayne <Cascio.Wayne@epa.gov>; Baxter, Lisa <Baxter.Lisa@epa.gov>; Bell, Matthew <Bell.Matthew@epa.gov>
Cc: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: High level summary/Talking Points -- Internal Document/Not for Distribution

Are we going to have the spreadsheet in teams? Of should I print one for Doug?

From: Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Sent: Thursday, June 25, 2020 10:16 AM
To: Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Richardson, RobinH <Richardson.RobinH@epa.gov>; Cascio, Wayne <Cascio.Wayne@epa.gov>; Baxter, Lisa <Baxter.Lisa@epa.gov>; Bell, Matthew <Bell.Matthew@epa.gov>
Cc: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: High level summary/Talking Points -- Internal Document/Not for Distribution

Below is a summary of facilities needing a decision this week : **Ex. 5 Deliberative Process (DP)**

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Lynnann Hitchens
Acting Deputy Assistant Administrator for
Administration and Resources Management
Office of Mission Support
US EPA
P: 202-564-3184
M: Ex. 6 Personal Privacy (PP)

Message

From: Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]
Sent: 6/22/2020 9:29:11 PM
To: Jackson, Yvette [Jackson.Yvette@epa.gov]; Daniels, Alva [daniels.alva@epa.gov]
CC: Morina, Lenee [Morina.Lenee@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
Subject: Facilities Update
Attachments: HQ Phase 1 MM 6-22-2020_VS2_OA_DV_LH Final.docx; 2020_EPA_OMS-Mass2_HQ.jpg

Importance: High

Hi Yvette, attached is the facility update to HQ employees about our Phase 1 reopening. Donna wants this go asap. I've also attached the OMS banner.

Please let me know if you need anything else.

Shakeba Carter-Jenkins
Communications Director &
Senior Special Assistant
Office of Mission Support, U.S. Environmental Protection Agency
carter-jenkins.shakeba@epa.gov | 202-564-6385 | Ex. 6 Personal Privacy (PP) *(mobile) | WJC North 3330*
Mailing Address: 1200 Pennsylvania Avenue, NW, Washington, DC 20460

"I've learned you can tell a lot about a person by the way (s)he handles these three things: a rainy day, lost luggage, and tangled Christmas tree lights." Maya Angelou

Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 7/20/2020 5:52:45 PM
To: Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Braxton, Marilyn [Braxton.Marilyn@epa.gov]
Subject: RE: QFRs re: COVID

Ex. 5 Deliberative Process (DP)

From: Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Sent: Monday, July 20, 2020 11:23 AM
To: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>
Subject: RE: QFRs re: COVID

Marilyn –
I've added some comments to the attached. I tried to incorporate the Phase 3 guidance.

Ex. 5 Deliberative Process (DP)

Lynnann Hitchens
Acting Deputy Assistant Administrator for
Administration and Resources Management
Office of Mission Support
US EPA
P: 202-564-3184
M: Ex. 6 Personal Privacy (PP)

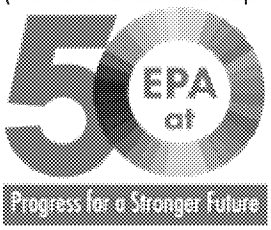
From: Braxton, Marilyn <Braxton.Marilyn@epa.gov>
Sent: Friday, July 17, 2020 11:12 AM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Subject: QFRs re: COVID
Importance: High

Donna & Lynnann,

Ex. 5 Deliberative Process (DP)

Marilyn

Marilyn A. Braxton, Chief of Staff
****
Office of Mission Support, US Environmental Protection Agency
braxton.marilyn@epa.gov | 202-564-8192 | Ex. 6 Personal Privacy (PP) (mobile) | WJC North 3330C
Mailing Address: 1200 Pennsylvania Avenue, NW, Washington, DC 20460, Mail Code: 3101A
(Hours: 8:30am – 6:00pm, compressed 2nd Friday)



Message

From: Mugdan, Walter [Mugdan.Walter@epa.gov]
Sent: 6/18/2020 9:17:42 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Grantham, Nancy [Grantham.Nancy@epa.gov]
Subject: FW: Region 2 Facility Status Update
Attachments: R2 Home Page 06-17-2020.pdf; R2 Criteria II 06-17-2020.pdf; Region 2 Reconstitution Plan.pdf

FYI, this just went out to all Region 2 employees. Thanks for keeping us closely up-to-date about all the developments!

From: Hickey, Maureen <Hickey.Maureen@epa.gov> **On Behalf Of** Lopez, Peter
Sent: Thursday, June 18, 2020 5:16 PM
Cc: Lopez, Peter <lopez.peter@epa.gov>
Subject: Region 2 Facility Status Update

Dear Colleagues,

Thank you again for your continued patience and perseverance as we work to advance our mission of protecting public health and the environment, while addressing the challenges associated with COVID-19. Maintaining the health and safety of our workforce while fulfilling our mission responsibilities is our top priority.

At this time I am writing to advise you that four of our eight Region 2 office locations will commence the 7-day "no entry" closure period, preceding implementation of Phase 1, starting at close of business on Monday, June 22. The offices in question are: 290 Broadway, Edison, Buffalo and Stamford, CT.

As Administrator Wheeler mentioned, the Agency's plan to safely return to the office will consider scientific data, an evaluation of site-specific conditions, and state and local orders. With communities expected to recover at different speeds, location-specific conditions are driving decisions to ensure people are reoccupying our offices in a way that is safe while having the appropriate protective measures in place. I want to reiterate that our plan is to continue robust usage of unscheduled telework as we transition back to supporting in-office operation.

Agency experts in the Office of Research and Development have been providing information on the status of each gating criterion in the commuting area surrounding our facility locations each week. The review showed that our New York City, Edison, Buffalo and Stamford, CT locations are meeting the gating criteria. (Please see the attached charts excerpted from the Facility Status Dashboard showing information for the New York City commuting area. A link to the Dashboard, which is updated weekly on Wednesdays, was shared with all employees on June 12. The updated version will be available this evening, and will include our Edison, Buffalo and Stamford locations. As I wrote in my email on June 12, data for our Caribbean locations and our Hudson River Office location in Albany are not yet included in the Dashboard.)

On June 8 New York City entered Phase 1 of New York State's 4-phase process; all other parts of New York State are now in either NYS Phase 2 or Phase 3. See: https://forward.ny.gov/#:~:text=NYC%20is%20in%20Phase%201,in%20Phase%203%20of%20reopening. The following site also has useful information about NYS conditions: https://nymag.com/intelligencer/2020/06/when-will-new-york-reopen-phases-and-full-plan-explained.html.

On June 15 New Jersey entered Phase 2 of its 3-phase reopening. See: https://covid19.nj.gov/. On May 20 Connecticut entered Phase 1 of its 3-phase reopening. See: https://reopen.ct.gov/

We are therefore moving forward with our phased approach to return to normal working operation at our the above-mentioned in accordance with the information outlined in the EPA Return to the Workplace document that was previously shared with all employees.

Our phased return to normal operations will happen gradually, beginning with the 7-day closure starting at COB Monday. This closure, as outlined in the EPA/CDC Cleaning and Disinfection Guidance, will render the virus inactive; and once we reopen, we will remain committed to keeping our facilities properly cleaned and sanitized. We are also working to ensure that the buildings in which our Buffalo and Stamford offices are located are being maintained following CDC's guidance on optimum engineering controls for the building ventilation systems and CDC Guidance for Building Water Systems. Our own buildings in Edison are following that guidance, and of course that guidance is being followed at 290 Broadway.

I want to provide you with information on what to expect as we move through the gating phases. We are instituting new procedures outlined below during the first two phases as we slowly return to the office. We are undertaking these measures in order to safeguard and prioritize the well-being of our employees. We believe that instituting CDC-recommended social distancing protocols, continuing to leverage telework and work schedule flexibilities, and tightly controlling access to EPA space will better protect our health and safety while ensuring that we are able to continue performing the important work of the Agency.

The Agency will continue to adjust and update its guidance as appropriate based on CDC recommendations as well as local guidance. Guidance on the new day-to-day procedures that will be in effect during Phase 1 and Phase 2 is provided below, as well as in the more detailed Region 2 implementation plan attached to this message. These documents will continue to be updated as more detailed information becomes available. I also encourage you to keep checking the EPA COVID-19 page for links to resources and helpful tips for employees.

Maintaining the health and safety of our workforce while fulfilling our mission responsibilities is our top priority. We understand you may have questions about reopening. We will share more information as it becomes available, and we are planning an All Employees meeting for next week (watch for a separate invitation). In the meantime, please talk to your supervisor if you have questions; we will work with them to provide answers.

Thank you for your continued dedication to our mission.

Pete

Telework and Work Schedule Flexibilities	**Phase 1** - We encourage all employees to use unscheduled telework and will continue to offer the expanded work hours and workweek flexibilities for those on Maxiflex or Flexitour schedules. Facilities will be open, and employees have the option to return to the workplace. Employees who the CDC identifies as being at higher risk for severe illness from COVID-19 or pregnant women and those with household members in that population should continue to telework. **Phase 2** - We will continue to encourage all employees to use unscheduled telework, notifying their supervisor if they choose to do so. Facilities will be open, and employees have the option to return to the workplace. Employees who the CDC identifies as being at higher risk for severe illness from COVID-19, pregnant women, and those living with members that are part of these vulnerable populations should continue to telework. The expanded work hours and workweek flexibilities will continue to be available to those with dependent care issues and on a Maxiflex or Flexitour schedule. All other employees must return to normal work schedules.
Building Access	During Phase 1 and 2, facilities will be open, and employees have the option to return to the workplace. We ask that each employee who goes into the office self-screen by reviewing the

	self-assessment questionnaire prior to leaving their residence, and to not enter the building if they answer yes to any of the listed questions.
Local Orders (face coverings)	Both New York and New Jersey require face coverings when in public. Therefore, face coverings must be worn by those entering the 290 Broadway, Edison and Albany buildings and where social distancing cannot be maintained. Employees must continue to wear a face covering when in a common area inside the building (e.g., pantries, restrooms, hallways, etc.) and those seeking services (e.g., badging, IT services) must wear a face covering at the time of service regardless of local or state orders. We will notify you if the local order changes.
Social Distancing	Social distancing guidelines will be implemented and maintained between people throughout the facility. Employees should not congregate in these areas, including but not limited to: ▪ Entry and exit doors ▪ Lobbies and foyers ▪ Elevators and stairwells ▪ Hallways and corridors ▪ Restrooms ▪ Pantries, kitchen and break areas ▪ Photocopy and printer areas ▪ Open floor environments (e.g., labs, warehouses, etc.) Signage will be posted to notify staff of occupant limit, seating restrictions, or other restrictions throughout the facility. **Meeting Rooms**: Employees should use virtual meetings when possible. Smaller conference rooms will be closed and locked; larger ones should only be used if appropriate social distancing can be maintained.
Visitor Access to Buildings	**Phase 1** - Facilities will be closed to visitors. **Phase 2** - Facilities are open to visitors for mission-essential work purposes only.
Work Travel	For travel during the phased return to workplaces, offices should follow the June 5, 2020, "Travel Guidelines During the Phased Return to Workplaces" memo. **Phase 1** - Travel will be limited to essential travel and must be approved by the RA prior to entering the travel authorization into Concur. An assessment of the local conditions at departure and destination locations, and any necessary connection points, must be considered. A request for approval should be submitted to the Director of MSD, who will coordinate with the RA. **Phase 2** - Nonessential travel may resume and may be approved by the traveler's supervisor. Consideration of local conditions at departure and destination should continue. Please see the above-linked memo for full guidance. Consolidated agency guidance for inspections and for field work is also in progress and should be used for those activities.
Contact Tracing	Throughout all Phases, the Agency will utilize its guidance to notify and trace when an employee has tested positive for COVID-19.

EPA Facility Status Dashboard - Draft version for Weekly Management Review

About | Home | Criteria I | Criteria II | Criteria III

Last updated: **06/17/2020**

EPA Facilities

- COVID-19 cases are not trending down
- COVID-19 cases are trending down over the previous 7 days
- COVID-19 cases are trending down over the previous 14 days **OR** incidence rate is below 10 per 100,000 people over the previous 14 days

Headquarters
1200 Pennsylvania Ave., NW
Washington, DC 20004-2403

Region 1 Headquarters
90 Devonshire St.
Boston, MA 02121-0000

Region 2 Headquarters
290 Broadway
New York City, NY 10007-1866

Region 3 Headquarters
1650 Arch Street
Philadelphia, PA 19103-2029

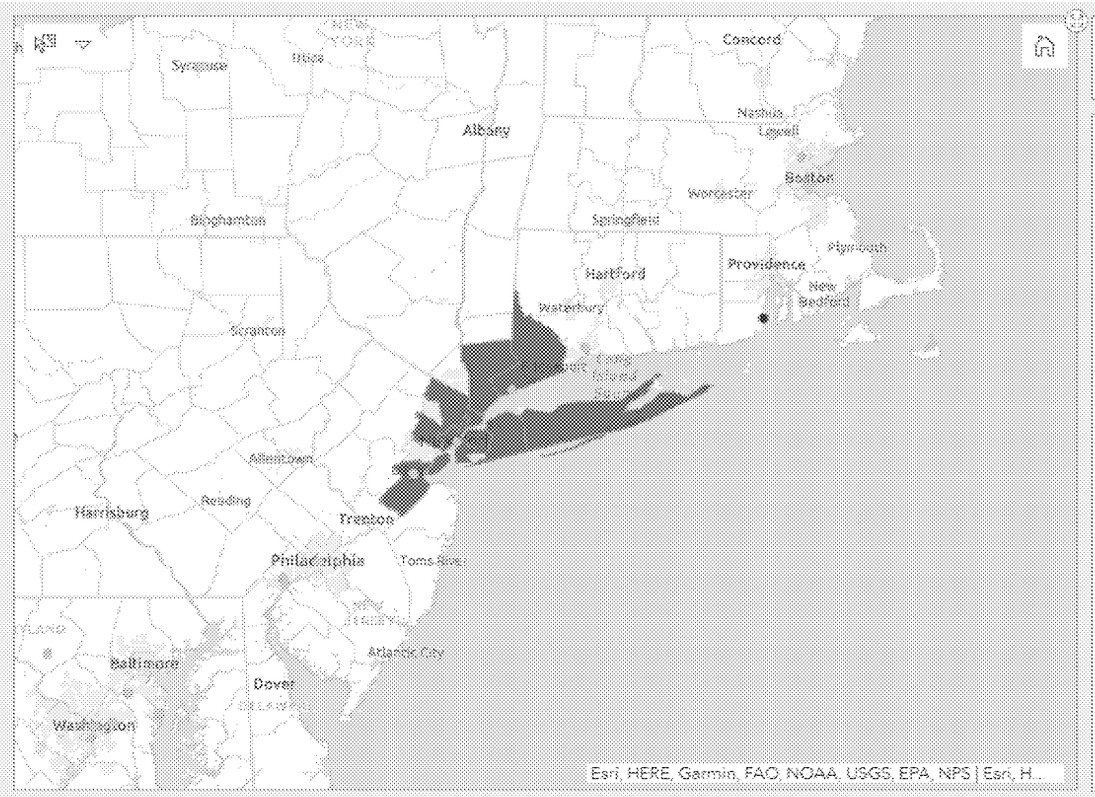
Region 4 Headquarters
61 Forsyth Street SW
Atlanta, GA 30303-8960

Region 5 Headquarters
77 West Jackson Boulevard
Chicago, IL 60604-3511

Region 6 Headquarters
1201 Elm Street
Dallas, TX 75270-0000

Region 7 Headquarters
11201 Renner Blvd
Lenexa, KS 66219

Region 8 Headquarters



Criteria II

Documented COVID-19 cases and prevalence of positive tests must trend downward for 14 days (while not decreasing the overall number of tests).

Daily New Covid-19 Cases (previous 28 days)

See About Tab for how trend was determined

Population	Confirmed COVID-19 Cases (all cases)	COVID-19 Incidence Rate (previous 14 days)
8,447,725	217,496	65.7 cases per 100,000 people

14 Day Trend

New COVID-19 cases are trending down over the previous 14 days

Goal: Downward trend for 14 days

14 Day Trend

This trend is statistically significant

p-value = 0.0004

EPA Facility Status Dashboard - Draft version for Weekly Management Review

About | Home | Criteria I | Criteria II | Criteria III

Last updated: **06/17/2020**

EPA Facilities

- Facility is not meeting all criteria
- Facility is meeting all criteria over the previous 7 days
- Facility is meeting all criteria over the previous 14 days

Headquarters DC
1200 Pennsylvania Ave., NW
Washington, DC 20004-2403

Region 1 Headquarters
90 Devonshire St.
Boston, MA 02121-0000

Region 2 Headquarters
290 Broadway
New York City, NY 10007-1866

Region 3 Headquarters
1650 Arch Street
Philadelphia, PA 19103-2029

Region 4 Headquarters
61 Forsyth Street SW
Atlanta, GA 30303-8960

Region 5 Headquarters
77 West Jackson Boulevard
Chicago, IL 60604-3511

Region 6 Headquarters
1201 Elm Street
Dallas, TX 75270-0000

Region 7 Headquarters
11201 Renner Blvd
Lenexa, KS 66219

Region 8 Headquarters
1695 Wynkoop Street
Denver, CO 80202-0000

Criteria I

Downward trajectory of influenza and COVID-like illness (ILI / CLI) symptoms within 14-day period

Goal I-a: Number of reported weekly new ILI symptoms averaged over the states that intersect the commuting area trends down over a 4-week period

AND

Goal I-b: Number of reported weekly new CLI symptoms averaged over the states that intersect the commuting area trends down over

Goal I-a

Statewide ILI Symptoms are trending down or there is minimal ILI activity

Goal I-b

tbd

Criteria II

Documented COVID-19 cases and prevalence of positive tests must trend downward for 14 days (while not decreasing the overall number of tests

Goal II-a: Number of reported daily new cases in the commuting area trends down over a 14-day period

AND

Goal II-b: Number of reported positive tests in the commuting area trends down over a 14-day period

OR

Goal II-c: Incidence over the previous 14 days is less than 10 cases per 100,000 people

Goal II-a

New COVID-19 cases are trending down over the previous 14 days

Goal II-b

tbd

Goal II-c

Incidence over last 14 days

65.7

cases per 100,000 people

Criteria III

Local hospitals must have the capacity to treat all patients without crisis care and jurisdictions must have a robust healthcare worker testing program and plan in place

Goal III-a: ICU bed capacity for all hospitals in the commuting area is greater than 20%

AND

Goal III-b: Percent of positive tests averaged over the states that intersect the commuting area is below 20%

Goal III-a

ICU Capacity Remaining

63.4%

Goal III-b

Percent of COVID-19 tests that are positive

14.9%

Region 2 Reconstitution Plan

Last updated June 18, 2020

Background

This guidance provides information for employees on the return to the workplace process the Region will follow. This document touches upon the criteria used to determine when to return to the office and focuses on the large multi-divisional offices. This document should be considered a "living" document that may be subject to change as conditions or other situations warrant. The Region will follow the memorandums published by the Office of Management and Budget (OMB) and the Office of Personnel Management (OPM) on April 20, 2020, establishing criteria for federal agencies to assess before reoccupying facilities. These criteria provide guidance to all federal agencies as they make reopening decisions. The gating criteria are:

1. Influenza-like illnesses and COVID-like cases of illness must trend downward for 14 calendar days;
2. Documented COVID-19 cases and prevalence of positive tests must trend downward for 14 calendar days; and
3. Local hospitals must have the capacity to treat all patients without crisis care; and
4. Jurisdictions must have a robust healthcare worker testing program and plan in place.

Headquarters, in consultation with Regional leadership, will review the gating criteria and consider the decisions and guidance of state and local authorities in areas where EPA has facilities before making any reopening decisions. The Region will follow guidance published by the Center for Diseases Control and the U.S. EPA. The phasing plan follows the White House Coronavirus Task Force issued Guidelines for Opening Up America Again which establishes a phased re-opening process for businesses, government agencies, and other public facilities.

No one can enter any EPA space without performing the EPA Self Assessment checklist.

Guidance for all individuals and all locations:

- Consult the EPA Return to Work FAQ page.
- Adhere to CDC guidance of maximizing physical distance from others.
- Avoid socializing in groups of more than 10 people in circumstances that do not readily allow for appropriate physical distancing
- Continue to practice good hygiene:
  - Wash your hands with soap and water or use hand sanitizer, especially after touching frequently used items or surfaces.
  - Avoid touching your face.
  - Sneeze or cough into a tissue, or the inside of your elbow.
  - Disinfect frequently used items and surfaces as much as possible.
  - Follow appropriate local, state, CDC or other guidance regarding the use of face coverings while in public especially when social distancing is not possible.
- People who feel sick should stay home:
  - Do not go to work.
  - Contact and follow the advice of your medical provider.
- Employees: inform your supervisor if you become sick or begin to experience symptoms

Disclaimer: This plan addresses the reconstitution of Region 2 business operations and focuses on the re-opening of its three larger offices. Although the satellite offices are not discussed, the principles of how those offices will re-open will be similar to this plan. All satellite offices should expect to implement most of these controls and should consult with their respective Division and/or MSD staff before resuming normal operations.

Phased Reconstitution

The Region will deactivate the Continuity of Operations Plan (COOP), reconstitute and return to work through three phases. This document provides a list of restrictions, limitations and operating procedures for the Region as well as limitations and procedures specific to each of our major locations for each phase.

7-Day Office Closure Period (Phase 0)

In order to maximize the safety of employees, we will close all offices where nonessential work is being done for no less than seven days. The seven-day closure ensures that Region spaces are in compliance with CDC guidance that only normal, routine cleaning is needed to open the area. The decision to enter Phase 0, as well as the decision to enter Phases 1-3, as described below, will be made for each location.

No one will be permitted to enter EPA space during this period (exception: fire or other like emergency). This includes all Operations and Maintenance (O&M), janitorial, ERT and/or OLEM staff at the Edison Environmental Center. MSD personnel have developed a plan utilizing the Physical Access Control System (and other procedures) to restrict access to Region's space. This procedure will be followed in addition to all routine and existing cleaning of common spaces since activating the COOP.

COOP Deactivation

Before transitioning from an *active* COOP to Phase 1, the Region will notify all employees of the beginning of the 7-day closure period and the day it is expected to transition to Phase 1.

Communication

- Region 2 personnel will be kept apprised of COOP / reconstitution activities using several communication channels. Based on the information that needs to be conveyed and the target audience, Senior Management and/or the R2 Reconstitution team will determine the most appropriate channel(s) to use. R2 communication channels include:
    - Mass Alert Notification System (MANS) (Everbridge) – As needed to send important mass notifications and updates to all R2 employees conveying information on COOP and R2 facility status if necessary, before and during phased reentry
    - All Hands Virtual Meetings – Held by the RA, DRA, & MSD DD to convey updates and answer questions
    - Agency Mass Mailers & R2 Leadership Emails – As necessary / as needed
    - R2 COVID SharePoint and Intranet – Used to centralize / reinforce / emphasize important Covid-19 & reconstitution information.

PHASE 1 – ALL LOCATIONS

Regional locations will enter Phase 1 upon satisfying the gating criteria, considering state and local orders and completing the seven-day closure period. The decision for transition to Phase 1 will be made for each location. During Phase 1, the following applies to all Region 2 facilities and staff:

Telework and Work Schedules

- COOP is deactivated, but employees will continue to be provided the flexibility of unscheduled telework and should continue to telework whenever possible and feasible with business operations.
- Employees in a category the CDC determines as High-Risk, those who are pregnant, or those living with a higher-risk or pregnant individual, should continue to telework during Phase 1.
- Employees with dependent care responsibilities because COVID-19 has interfered with existing or planned arrangements should also continue to telework during Phase 1.
- Employees may also continue to use expanded work hours and the expanded work week if on a Maxiflex or Flexitour schedule
- Telework is strongly encouraged through Phases 1 and 2. Employees requiring access to Region 2 space to retrieve documents, address IT issues, or perform essential work that can only be accomplished within Region 2 space must request access. The Region must ensure social distancing is observed and the health and well-being of all employees is maintained. All employee requests will adhere to the EPA self-assessment checklist.
- **Employees must request access to EPA space**. Physical access will be controlled to ensure social distancing. Requests will be reviewed against existing Region 2 floor plans to ensure social distancing is maintained. Employees should restrict traversing through office space to the maximum extent possible, limiting access to the cubicle/office space and other required space (i.e., file rooms, bathrooms) only.
- All employees requiring access should continue to follow access request protocols.
- All employees will perform a self-assessment before going to any EPA office.
- NO visitors to any EPA space during this phase.

Facility Operations and Health and Safety Controls

- Where required by the state or local jurisdictions, all personnel will wear CDC recommended face coverings in all facility common areas. Face coverings will also be required in office areas when social distancing is not possible. If not required by the state, the use of face coverings is highly recommended.
- All employees interacting with a help desk or colleagues will be required to wear face coverings during their interaction.
- Janitorial staff will disinfect high touch, high traffic locations frequently.
- Employees should adhere to social distancing protocols and good personal hygiene.
- Guidance in the form of CDC posters encouraging social distancing will be posted inside EPA space.

- All conference rooms which do not allow employees to practice social distancing will be closed and locked.
- Conference calls and virtual meetings are encouraged.
- All break room seating will be removed to prevent gatherings and practice social distancing.
- Mail operations will continue to follow the Region 2 MAILROOM COOP SOP.
- GOV operations will continue to be reserved and dispatched with the Region 2 COVID GOV SOP.
- Heating, Ventilation and Air-Conditioning (HVAC) and water systems will continue to operate and follow CDC , ASHRAE , and EPA guidance on systems maintenance where applicable.
- Water fountains will be closed for use, but water bottle filling stations will remain open, as will the kitchen sinks. (Note: all HVAC and water systems have been run throughout office closures in accordance with CDC guidance).
- All EPA-owned fitness centers will remain closed.
- Restrooms will have every other stall closed to prevent an excessive amount of persons in the restroom.
- Restrooms: Restroom occupancy will not exceed three persons. Each restroom will have an occupancy poster hung outside the door indicating current use. Employees will write their initials on a sticky note and take it with them to the restroom. When they arrive at the entrance, if there are already a maximum of three sticky notes affixed to the designated occupancy poster, the employee knows that the restroom is full and can either wait or find another restroom. If the restroom is not full, the employee affixes their note to the occupancy poster and proceeds in. The employee will reclaim their note as they leave before returning to their workstation.

Response to a COVID-19 Touchpoint in Facility

- Anyone (i.e., employees, other federal agency or department employees, contractors, grantees, SEEs, and other non-federal workforce members) meeting the definition of a COVID-19 affected person as outlined in the Agency's contact tracing guidance, is directed to contact their first line supervisor or monitor to inform them of their status, and either stay home if they are teleworking, or depart the office immediately.
- Employees who appear to have symptoms upon arrival at work or who become sick during the day should immediately be separated from other employees and be sent home.
- In conjunction with the Agency's contact tracing guidance, the Region will utilize its immediate action plan for cleaning, sanitizing and disinfecting spaces, including common areas, that may have been compromised by an employee who has become symptomatic and/or notified to have tested positive. In the event of an employee becoming symptomatic, obtaining a positive COVID-19 test result, or having had direct contact with a positive COVID case, the Region will provide notification to the affected office and individuals.
- (Supervisors): For contact tracing, report any staff who become symptomatic, received a positive COVID-19 test result, or have been notified to be in direct contact with a person

confirmed to have COVID19 to Frank Demarco and the Region's Health and Safety Officer immediately.

- EPA personnel who have been in direct contact with a COVID-19 affected person must notify their supervisor and self-quarantine for the earlier of 14 calendar days or until a negative test result is received. These individuals will be allowed two weeks of situational telework or appropriate leave.

Travel

- The region will follow the Agency's travel guidance issued by OCFO.
- Only essential travel will be approved.
- Adhere to CDC guidelines regarding isolation following travel.
- Videoconferencing or audioconferencing will be used for the majority of the coordination with stakeholders and internal meetings.
- All travel must be approved by the Regional Administrator (RA), through the Senior Resource Officer (SRO) (*i.e.,* the MSD Director).
- Travel requests submitted through the SRO for RA approval must be submitted no later than three days prior to the requested travel date to allow for approval and processing of the travel request.
- Prior to the traveler requesting the Financial Management Branch (FMB) Travel Help Desk (THD) to prepare his/her travel authorization (TA), the travel must be approved by the RA.
- Travel requests to support an emergency response can be approved via email or verbally by the responder's supervisor or Division Director with follow-up to the SRO and RA in writing when time allows.
- To get the approval, the traveler's Division Director will send an email to the SRO with the following information: travel dates, the departure and destination locations (including connection points), mode of transportation (i.e., rail, air GOV, POV), the purpose of the travel, a statement of why travel is essential, and a brief description on the local conditions at the departure and destination locations and any connection points. The SRO will review the information for concurrence and will then route the email to the RA for approval. The RA will review and respond to the requesting Division Director's email with the approval or disapproval for the travel.
- The traveler must attach a PDF of the RA's email approving the travel to his/her travel request submitted via the FMB Help Desk.
- FMB will not process requests that do not include the RA approval email.
- The THD staff will attach the PDF containing the RA approval, and any other justification/approvals (e.g., waivers for adjustments to travel logistics), to the TA in Concur.

PHASE 1 – NEW YORK REGIONAL OFFICE

Building Access

- Everyone intending to enter the building will be notified at the entrance to the facility that sick persons are barred from entry. Signage will be displayed explaining that persons who are sick, living with someone sick or who have been directed to quarantine in the last 14 days are barred from entry.
- The Facility Security Committee of 290 Broadway has closed the building to visitors. A visitor is defined as a person not having official business with the U.S. Government.
- Individuals will be required to adhere to the two-person limit on passenger elevators.
- Employees will NOT be required to enter their PIN for entry through the 290 Broadway GSA owned physical access control system.

Health and Safety Control Measures

- In accordance with New York State Executive Order No. 202.17, everyone entering the building will be required to wear face coverings in the building common areas (lobby, elevators, passageways).
- Employees will be required to adhere to social distancing signage posted in the lobby and throughout EPA space in the building.
- Individuals will be required to adhere to the two-person limit on passenger elevators.
- Hand sanitizer stations and wipes will be provided in elevator lobbies on EPA floors. Employees are encouraged to use hand sanitizer after disembarking from the elevator.
- Hands-free door openers have been installed on doors used to enter into EPA space on each floor. Employees are encouraged to utilize a hands-free door opener for elevator lobby doors.
- Employees are strongly encouraged to stay on their own floor during the workday. If they need to leave the floor, they should keep a log of their movements.

Access to MSD and other Services

- The Region's library will remain closed.
- The New York City IRMB Helpdesk will continue to maximize remote operations. An action that requires human-to-human interaction (e.g., laptop turn in, etc.) will be conducted by appointment only.
- The New York City IRMB Helpdesk will operate from the 2327 Computer Room. Employees not familiar with this space will follow signage on the 23rd floor.
- The New York City Physical Access Control System (PACS) badging office located on the 27th floor will remain closed.
- The USAccess station at 26 Federal Plaza will remain closed. Employees who have locked their PIV card must request a Local Area Connection exemption request via FAMB (7-3333). Note: PIV cards currently locked will continue to allow access to the building at the physical access control system entry.

PHASE 1 – EDISON ENVIRONMENTAL CENTER (EEC)

Facility Access

- Employees reporting to the office will be notified at the entrance to the facility that sick persons are barred from entry. Signage will be displayed explaining that persons who are sick, living with someone sick or whom have been directed to quarantine in the last 14 days are barred from entry.
- EEC is closed to all visitors. A visitor is defined as a person not having official business with the U.S. Government.

Health and Safety Control Measures

- In accordance with New Jersey Executive Order No. 122, all personnel will wear CDC recommended face coverings in all facility common areas. Face coverings will also be required in office areas when social distancing is not possible.
- Hand sanitizer stations and wipes will be provided throughout various buildings and bays. Employees are encouraged to use hand sanitizer.
- Hands-free door openers have been installed on doors used to enter into buildings. Employees are encouraged to utilize a hands-free door opener to access buildings.
- Interior building doors will remain propped open.
- Employees are strongly encouraged to stay in their building/bay during the workday. If they need to leave their area, they should keep a log of their movements.

Access to MSD and other Services

- The IRMB Helpdesk will continue to maximize remote operations. An action that requires human-to-human interaction (e.g., laptop turn in, etc.) will be conducted by appointment only. The IRMB Helpdesk will operate from within their space and utilize an air phone to speak to customers.
- The Edison PACS office and USAccess station will remain closed. Employees who have locked their PIV card must request a Local Area Connection exemption request via FAMB (1-6714).

PHASE 1 – GUAYNABO OFFICE

Facility Access

- (**Implemented by the Lessor**) Employees will be required to wear face coverings in the building lobby.
- (**Implemented by the Lessor**) Employees reporting to the office will be screened at the entrance to the facility. All employees will be asked if they are sick, living with someone sick or been directed to quarantine in the last 14 days.
- (**Implemented by the Lessor**) Employees reporting to the office will be given a temperature screening prior to entering the elevator lobby.

Health and Safety Control Measures

- (**Implemented by the Lessor**) Employees will be required to adhere to social distancing signage posted in the lobby.
- (**Implemented by the Lessor**) Employees will be required to adhere to the two-person limit on passenger elevators.
- Hand sanitizer stations and wipes will be provided in elevator lobbies in EPA space. Employees are encouraged to use hand sanitizer after disembarking from the elevator.
- Employees will be required to enter CEPD space via the reception area doors nearest Tradewinds Conference Room. Hands-free door openers have been installed on the interior reception doors and will be used to enter EPA space. The elevator lobby doors nearest the Rainforest Conference Room will be utilized for exit only.

Access to MSD and other Services

- The CEPD IRMB Helpdesk will continue to maximize remote operations. An action that requires human-to-human interaction (e.g., laptop turn in, etc.) will be conducted by appointment only. The CEPD IRMB Helpdesk will operate from the visitors' office 7124.
- The CEPD PACS office will remain closed.

PHASE 1 TRANSITION

Regional locations will enter Phase 2 upon satisfying the gating criteria a second time while also considering state and local orders. The Region will attempt to notify all employees, with as much anticipation as possible, of the day it will transition to Phase 2.

PHASE 2 – ALL LOCATIONS

Telework and Work Schedules

- Employees will continue to be provided the flexibility of unscheduled telework and should telework whenever possible and feasible with business operations.
- Employees in a category the CDC determines as higher-risk, those who are pregnant, or those living with a higher-risk or pregnant individual, should continue to telework during Phase 2.
- All employees, except as provided in the next bullet, should return to normal work hours and normal work week schedules.
- As provided for in Phase 1, employees with continuing dependent care responsibilities should still telework. These employees may also continue to work expanded hours and expanded work week if on a Maxiflex or Flexitour schedule after notifying their immediate supervisor.
- Employees choosing the option to telework in Phase 2 should notify their immediate supervisor.

Facility Access

- All controls implemented in Phase 1 stay in place during Phase 2 with the following exceptions:
- Visitors may be given access to EPA space during this phase only for mission-essential reasons. All visitors must conduct a self-assessment and declare that they are "not sick, not living with someone sick, nor been directed to quarantine in the last 14 days" in their visit request. All visitor requests will be submitted to FAMB.

Facility Operations and Health and Safety Controls

All controls implemented in Phase 1 stay in place during Phase 2 with the following exceptions:

- Mail operations will resume using the protocols followed pre-COOP operations.

Travel

- The region will follow the Agency's travel guidance issued by OCFO.
- Minimize non-essential travel and adhere to CDC guidelines regarding isolation following travel.
- Usual approval routing resume. No RA approval is required. Most internal meetings involving multiple locations will continue to be held via video conferencing or audioconferencing.
- As part of the approval criteria, the supervisor will take into consideration the local conditions at departure and destination locations, and any necessary connection points.
- Waivers related to adjustments to travel logistics needed for COVID impacts or local circumstances require documentation and must be attached to the TA in Concur. For example, choosing to use GOV or POV may be approved as waivers.

PHASE 2 – NEW YORK REGIONAL OFFICE

Building Access

- Building access controls and protocols remain unchanged from Phase 1.

Health and Safety Control Measures

- Health and safety control measures remain unchanged from Phase 1.

Access to MSD and other Services

- Access to MSD and other services remains unchanged from Phase 1 with the exception that the New York PACS office will operate by appointment only (7-3333). Employees will contact FAMB (1-6714).
- The USAccess station at 26 Federal Plaza will conduct business by appointment only. Please call FAMB (7-3333) before attempting to make an appointment.

PHASE 2 – EDISON ENVIRONMENTAL CENTER

Facility Access

- All facility access controls and protocols remain in place from Phase 1.

Health and Safety Control Measures

- All health and safety control measures remain unchanged from Phase 1.

Access to MSD and other Services

- Access to MSD and other services remains unchanged from Phase 1 with the exception that the Edison PACS office and USAccess station will operate by appointment only. Employees will contact FAMB (1-6714).

PHASE 2 – GUAYNABO OFFICE

Building Access

- Building access controls and protocols remain unchanged from Phase 1.

Health and Safety Control Measures

- Health and safety control measures remain unchanged from Phase 1.

Access to MSD and other Services

- An access to MSD and other services remains unchanged from Phase 1 with the exception that the CEPD PACS office will operate by appointment only. To schedule an appointment contact (7-5826).

PHASE TWO TRANSITION

Regional locations will enter Phase 3 upon satisfying the gating criteria a third time while also considering state and local orders. The Region will attempt to notify all employees, with as much anticipation as possible, of the day it will transition to Phase 3.

PHASE 3

Guidance regarding Phase 3 will be released after consultation with Senior Leadership and a thorough assessment of lessons learned from Phases 1 and 2, and continued consideration of guidance from CDC and state and local governments in our locations.

The status of mass transit will be evaluated to determine its impact on employees returning to the office. If mass transit is deemed to impact the return, workforce flexibilities such as expanded use of telework will be considered to mitigate the impact. More information on using public transportation during the COVID-19 pandemic is available at the CDC webpage, Protect Yourself When Using Transportation. To help facilitate the decision process for individuals pertaining to mass transit, please refer to:

MTA Bus and Train Service
New Jersey Transit Service
Port Authority Path Service
For Android or iPhones – download CityMapper or Transit app.for updated transit schedules including Citi-Bike & Ferries.

Contact
We understand questions will arise during this process. Employees are encouraged to reach out to their supervisors for questions and concerns. Supervisors will then direct questions and comments to the appropriate senior management staff.

PHASE PLATEAU OR REGRESS

The Region expects to transition from phase to phase progressing towards a more permissive work environment. However, the possibility that local conditions may regress exists. Depending on the local situation the Region may need to return to an earlier phase or remain in a current phase longer than originally planned. That decision will be made by Headquarters in consultation with the Regional Administrator. The Region will notify all employees of any decision to 'regress' or plateau via use of the Everbridge system and the Region's COVID information systems. Lastly, regression decisions will be made by location.

	Phase I	Phase II
Telework	Maximum Unscheduled Telework Strongly Encouraged	
Social Distancing	Maintained Whenever Possible	
Fitness Centers	Closed	
Library	Closed	By Appointment Only
Virtual meetings	Strongly Encouraged	
IT support	Virtual/In Person, By Appointment Only	
Badging/PIV Station	Closed	By Appointment Only
Conference rooms	Closed	
Mail Room	COOP SOP	Normal Operations
GOV	GOV SOP	
Janitorial	High Touch/Traffic Areas Cleaned Often	
Water Fountains	Closed	
Water Bottle Filling Stations	Open	
Bathrooms	Limited Access	
Ventilation	Continue to Operate and Follow CDC and ASHRAE Guidance Where Applicable	
Visitors	No	Mission Essential, By Appointment Only
Travel	Mission Essential Only, RA Approval	Supervisor Approval
Hand sanitizers/wipes	Throughout EPA Space	
Interior Doors	Propped Open	
Elevators	Limited Occupancy	
Face masks	Required in All Common Areas	
Kitchens/Pantries	No Tables/Chairs	
Notifications	Everbridge/Region 2 Intranet/Region 2 SharePoint COVID-19 site	
Signage	Social Distancing/Proper Hygiene Throughout EPA Space	
Access Doors	Hands-free Openers	

References

1. **Opening Up America Again**
2. **OMB Memorandum: Aligning Federal Agency Operations with the National Guidelines for Opening Up America Again.**
3. **Centers for Disease Control Coronavirus Disease 2019: Guidance for Business - Employers**
4. **Environmental Protection Agency COVID19 Guidance**

Appendices

1. **US EPA Region 2 Laboratory Reopening Guidance**

Additional References

MTA Bus and Train Service

New Jersey Transit Service

Port Authority Path Service

For Android or iPhones – download CityMapper or Transit app.

Appendix 1

US EPA Region 2 Laboratory Reopening Guidance

USEPA REGION 2 LABORATORY REOPENING GUIDANCE

June 18, 2020 Rev 3.1

This document is supplemental to Regional and National EPA and CDC reentry information . It should be used as an addendum/supplement to available CDC, State of NJ, Middlesex County, and USEPA guidance. As guidance is finalized in our Region this supplemental plan will be updated as necessary.

Basic Guidelines for Returning to the Laboratory/Office

⇒ All occupants must follow all health, safety and chemical management and use rules and precautions (gloves, lab coats, and eyewear at all times in the lab).

⇒ All occupants must follow social distancing requirements.

⇒ All occupants must follow proper hand hygiene etiquette.

⇒ All occupants must follow all coughing and sneezing etiquette.

⇒ Vendors will not be allowed on site during Phase I unless mission critical work is needed.

⇒ All onsite visitors and vendors must wear masks during time on site at all times.

⇒ Vendors/techs on site as well as maintenance from onsite contract will be scheduled/controlled to maximize social distancing and cleaning/wipe down of area worked by vendors/techs should be performed.

⇒ Equipment Temperature Checks and balance calibrations will be completed by 8:00 am.

Telework will be encouraged for employees that have portable work, as long as laboratory tasks are completed.

During Phase 1 and 2 of the laboratory reopening, individuals with underlying conditions or other health concern/issues (See CDC guidelines) should contact the Branch Chief to continue teleworking.

Employees are required to perform the following self-assessment prior to coming to work each day:

Do you feel unwell or have <u>any</u> of the following CDC identified symptoms/scenarios of COVID-19 disease:

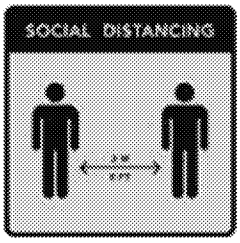
- Temperature of 100.4 degrees F or higher (38.0 degrees C)?
- Fever or chills?
- Cough or shortness of breath?
- Muscle pain?
- Headache?
- Sore throat?
- New loss of taste or smell?

- Within the last 14 calendar days, have you been in close contact (within 6 feet) of someone who has an active case of laboratory-confirmed COVID-19?
- Within the last 14 calendar days, have you been in close contact (within 6 feet) of someone who is ill or demonstrates any of the above symptoms?
- Within the last 14 calendar days, have you received instructions from a public health authority to self-observe, self-isolate, or self-quarantine?
- Within the last 14 calendar days, have you traveled outside of the United States?

If you answered "yes" to any of these questions, please stay home.

Please notify your supervisor and expect to telework, if possible, or take leave. It is recommended that you visit <u>www.coronavirus.gov</u>. You should also stay in touch with your supervisor on your status.

SOCIAL DISTANCING -General



The flow of traffic to and from Bay D will be controlled using one way in and one way out from Bay C to Bay D to limit the number of people passing in common areas and maximize social distancing. To go from Bay D to Bay C, only use the door near the printers at the back Bay D. To enter Bay D from Bay C only use the doors by the GC/MS Lab. The door outside the lab admin area will not be used and will be closed until further notice. Signage for traffic flow will be placed in 209 Bay C and D.

- If your individual laboratory has a door, if possible, leave door open a few inches so that coworkers can get your attention without touching door handle.
- Compliance with CDC guidelines on social distancing must be observed at all times.
- **Specific recommendations for the Region 2 Laboratory is as follows:**

a. There will be no table or chairs in the break area in Bay D.

b. It is recommended that lunches should be stored in employee offices in insulated lunch packs with ice packs.

c. As of 5/21/20, the food storage refrigerators can be used. Please DO NOT share contents that are in the fridge including condiments and keep space around food packages.

d. Please limit the break area to one person at a time if retrieving food from the fridge or using the microwave.

e. Wipe down handle of fridge and/or microwave with sanitizer/bleach solution after each use.

f. Maintain a social distance of 6 feet otherwise face coverings must be worn.

f. Do not stand outside of anyones cubicle or do not gather in hallways or common areas.

g. The conference room in 209 Bay D will not be in use until further notice. Plan on the use of office phones, cell phones, Skype, etc. for communication as much as possible.

h. If gatherings of 2 or more are neccessary, a space large enough to maintain at least 6 feet of distance between attendees should be chosen, otherwise face coverings are needed.

i. If possible, choose open spaces such as outside areas where staff can stand or sit without utilizing tables or chairs.

J. In order to minimize any chances of contamination of cubicles, space sharing should not be permitted in the office area. The scanning cube will be dedicated to the Summer Intern otherwise it should not be used. If you have a reasonable accommodation for a stand up desk, since this is in the scanning cube, please see Ann -Heng.

Any instances of employees not following these social distancing guidelines should be reported to the Branch Chief or the lab safety officer Ann-Heng.

General Lab Social Distancing Practices:

-Only one analyst per laboratory at any one time whenever possible

-If more than one analyst per lab than observe social distance or wear face covering

-Use dedicated instruments whenever possible

-Staggered shifts in the lab (AM/PM) or staggered days

-Possible weekend workdays for high surge sample backlog

-Save as much data work up as possible to use as portable work for telework hours

-Wipe down common touch areas with CDC approved cleaner routinely

Region 2 Lab Specific Distances Practices:

⇒ There should only be one analyst at a time in the balance room. Please wipe down balance and weighing table with sanitizer/ bleach after use.

⇒ Wear face coverings when walking through or using the common areas of the laboratory including OSCAR Station, Glassware Washing Room, and Balance Room.

⇒ Double occupant labs still require social distancing. If social distancing of at least six feet is achieved, face covers do not have to be used but are suggested.

⇒ In instrumentation labs (where solvents and corrosives are not routinely used), please consider performing data work up, routine administrative work, and Skype meetings if it is not too noisy to minimize time in common office area of Bay D.

⇒ Please keep doors ajar a couple of inches. This allows others to get your attention without touching door handles.

⇒ Frequently and thoroughly wash your hands with soap and water for at least 20 seconds. If soap and water are not available, use hand sanitizer with at least 70% alcohol.

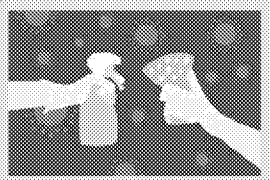
⇒ Wash hands after coming in contact with commonly touched areas (refrigerators, balances, pipets, sample bottles) and change gloves often.

⇒ Cover coughs and sneezes with a tissue, then throw the tissue in the trash, or use your inner elbow or sleeve.

⇒ Avoid touching your eyes, nose, and mouth with unwashed hands.

GENERAL CLEANING INFORMATION

-Contract cleaning staff will clean in the laboratory hallways but not be permitted in any laboratories except for garbage pick up. Alternatively, you may also place your garbage outside your laboratory by 4:00 pm each day for pick up or use the general waste cans in hallway.



-Facilities/OMS will provide sanitizers, including wipes and sprays. The Laboratory will continue to provide gloves, safety glasses, face shields, disposable masks and can supplement OMS supplies with specific cleaners if needed

-It is the responsibility of each bench-level staff member to clean and disinfect their laboratory area each day at the end of their shift. This is required in all Laboratory areas of all staff and is particularly important in areas that are used by more than one staff member.

-In addition to good glove and hand washing/sanitizing hygiene, please plan to wipe down all door handles, computer keyboards, hand touched parts of instruments, all door, sink and hood handles shared items such as balances and pipets at the end of your day/shift in the laboratory.

-Clean high touch surfaces in your workspace and personal items such as cell phones, ID cards/ badges and keys with disinfecting wipes or sprays.

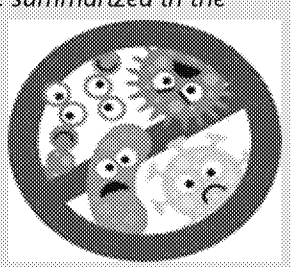
-Frequent disinfection of surfaces and objects touched by multiple people is important.

-When EPA-approved disinfectants are not available, alternative disinfectants can be used (for example, 1/3 cup of bleach added to 1 gallon of water, or a 70% alcohol solutions). Do not mix bleach or other cleaning and disinfection products together. This can cause vapors that may be very dangerous to breathe in. Bleach solutions will be effective for disinfection up to 24 hours.

-Continue to follow proper hand hygiene practices before and after glove use and throughout the workday.

-Lab cleaning and facility guidelines after someone has identified as sick or being around sick people:

An EPA National committee is currently working on this procedure and it will be summarized in the overall EPA Region 2 Reconstitution Plan.



Lab Sample/Handling Safety Procedures /PPE

OSCAR staff will follow the agreed upon cleaning and cooler receiving procedure (Region 2 Lab Sample Receipt Guidance-Attachment 1).

When working with samples always wear typical PPE - safety glasses, gloves, and lab coat. Also consider using the sash of a hood or a splash shield if working with waste water samples.

FACE COVERINGS:

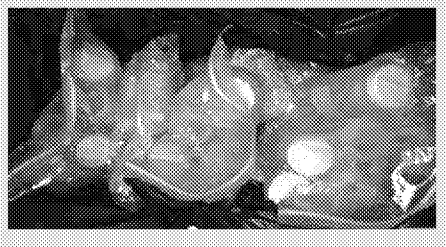
Based on current local/state and CDC guidelines, facemasks are required in all common areas including hallways, office space, and restrooms. When working in individual laboratories and sample prep areas and social distancing can not be maintained, please wear a disposable mask and replace daily (EPA provided). Please feel free to wear your own personal facemask in the office and common areas. All visitors and vendors will be required to wear face coverings when social distancing is not possible.

LABCOATS:

Lab coats will be washed more frequently. Currently everyone should have 3 lab coats. We are planning to have the coats laundered every 2 weeks. We will order 2 additional lab coats for all EPA and ESAT analytical staff. There are also blank lab coats available for use as well. Lab coats must not be brought in or worn in office/cubicle areas.

1. State of NJ Coved 19 Information Page
2. USEPA Covid 19 Internet Information Page
3. USEPA Covid 19 Intranet Information Page
4. USEPA Region 2 Covid 19 FAQs
5. CDC Building Disinfection Guidance
6. How to Don and Doff Protective Masks - You Tube Video
7. CDC How to Take Off Gloves

ATTACHMENT 1 -USEPA REGION 2 LABORATORY SAMPLE RECEIPT PROTOCOL



Sample collection/delivery:

1. Each sample bottle shall be placed in an individual resealable plastic bag. If no outer bag present, remove sample from cooler, pat dry, and set on table closest to glassware room ("Dirty" Table) to await wipe down with disposable beach based wipe or bleach solution (See 8a. below).

2. Samples, if needed, shall be put in ice, and placed in a disposable transport vessel (preferably)

3. For samples that are hand delivered, Styrofoam coolers which can be disposed of after one use, would be preferable. Styrofoam coolers are not recommended for samples to be shipped commercially due to durability concerns.

4. Wet ice is preferable to ice packs. Ice packs will not be returned or deconned but disposed of as trash.

5. If samples are to be hand delivered, social distancing must be maintained (6 feet) between person dropping off samples and EPA OSCAR personnel. The visitor must wear a face covering upon entry into the facility.

6. Sample coolers delivered by security staff and/or mailroom should be placed in walk in cooler or if OSCAR personnel are present during delivery, may be placed on the table closest to the Glassware Washing room (see 8a below).

7. Plastic coolers will need time to be decontaminated so they will not be ready from immediate return to the person who dropped it off.

Sample receipt:

8. One OSCAR Staff or person responsible for login wearing appropriate PPE (nitrile gloves, safety glasses and lab coat) will at a minimum follow the following guidelines:

A. There are 2 large tables in the sample receipt area. The table closest to the glassware washing room should be used as the "Dirty" table. Coolers received initially and samples, after removal from the cooler and patted dry, should be staged on this table. Once samples are patted dry then wiped down with a sanitizing wipe or bleach solution the sample bottles should be placed on the "Clean" table or table closest to login computer.

B. Wipe the cooler handles and lid clasp area immediately upon receipt with a disposable beach based wipe or towel soaked with a bleach solution (1/3 cup bleach and 1 gallon of water)

C. Working within the cooler, remove sample(s) from the bags – Pat dry with towels if wet and place on the "Dirty" table.

D. Place ice and outer bags into sink at the OSCAR Station.

E. Wipe down the outside of the sample containers with either a disposable bleach-based wipe or a disposable towel with a 1/3 cup of bleach per gallon of water solution applied. After decon of the sample bottles, they should be situated on the "Clean" table. This is the long table closest to the log in computer.

F. Let Samples sit for 10 minutes on the "Clean" table.

G. Change gloves as needed but always don a new pair when handling decontaminated sample bottle(s).

H. This is the point where sample labels may be checked against the chain of custody and information transferred into LIMS.

I. If sample transport cooler is not disposable, wipe down the outside and inside with either a disposable bleach-based wipe or a disposable towel with a 1/3 cup of bleach per gallon of water solution applied.

J. Let cooler sit for 10 minutes.

K. After each cooler shipment/processing: Dispose of resealable bags, all used wipes, gloves, transport container (if styrofoam or disposable) and other waste by placing in 40 gallon refuse bin in OSCAR.

L. After each set of samples processed, wipe down the sample receipt area (the tables for sample processing must be a hard surface that can be deconned (no permanent absorbant pads) and the sink in the OSCAR should be wiped down with a disinfectant wipe, bleach solution, or sprayed with bleach based product after each use during sample log in.

M. The garbage bag must be tied/taped for disposal at the end of the day.

Sample Analysis:

9. Conduct analyses using the appropriate level of normal PPE needed for the analyses being conducted.

For any H&S concerns, contact Ann-Heng Jen at 732-321-4340.

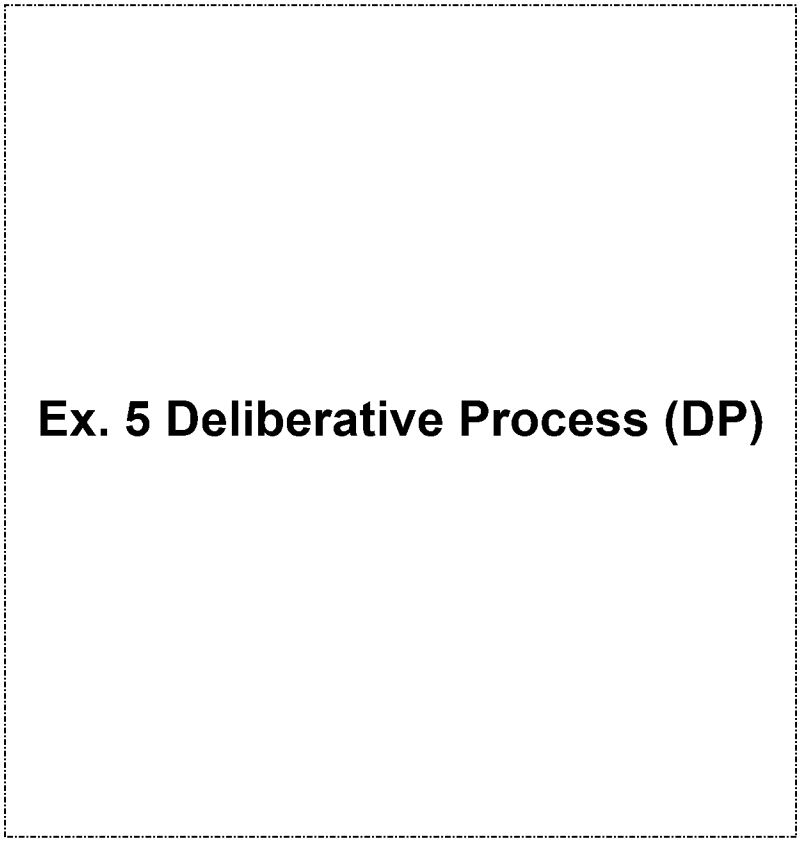
Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 6/17/2020 5:45:49 PM
To: Benevento, Douglas [benevento.douglas@epa.gov]
CC: Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Robbins, Chris [Robbins.Chris@epa.gov]; Richardson, RobinH [Richardson.RobinH@epa.gov]
Subject: RE: Facility Decisions

Doug, here is the list of the facilities that we will need to look at tomorrow. Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP) Please let me know if you need anything else.



Message

From: Braxton, Marilyn [Braxton.Marilyn@epa.gov]
Sent: 6/18/2020 8:25:47 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
CC: Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]
Subject: RE: need HQ mailer from me to enter phase 1
Attachments: HQ Phase 1 MM_6-17-2020 (002).docx

Edited (including Larry's update) with a few things to note:

Ex. 5 Deliberative Process (DP)

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, June 18, 2020 3:09 PM
To: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Cc: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: need HQ mailer from me to enter phase 1

Edits and a few questions in the attached

From: Braxton, Marilyn <Braxton.Marilyn@epa.gov>
Sent: Thursday, June 18, 2020 1:51 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Cc: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: need HQ mailer from me to enter phase 1

Sorry…revision attached

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: Braxton, Marilyn
Sent: Thursday, June 18, 2020 1:22 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>
Cc: Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: need HQ mailer from me to enter phase 1

The draft for HQ is attached. Just need our snippet

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, June 18, 2020 1:14 PM
To: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: need HQ mailer from me to enter phase 1

Message

From: Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]
Sent: 6/17/2020 2:02:52 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
Subject: FW: ORD role in Phase 3(b)?

Jennifer Orme-Zavaleta, PhD
Principal Deputy Assistant Administrator for Science
Office of Research and Development
US Environmental Protection Agency

DC 202-564-6620
Cell Ex. 6 Personal Privacy (PP)

From: Cascio, Wayne <Cascio.Wayne@epa.gov>
Sent: Wednesday, June 17, 2020 8:38 AM
To: Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>
Subject: RE: ORD role in Phase 3(b)?

Good morning Jennifer – Here are some thoughts Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Wayne E. Cascio, MD, FACC | Director | Center for Public Health and Environmental Assessment | Office of Research and Development | U.S. Environmental Protection Agency | Research Triangle Park, NC 27711 | Phone: 919.541.2508 | Cell: Ex. 6 Personal Privacy (PP)

From: Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>
Sent: Wednesday, June 17, 2020 7:09 AM
To: Cascio, Wayne <Cascio.Wayne@epa.gov>
Subject: FW: ORD role in Phase 3(b)?

See below fyi and interested in what you think on this

Jennifer Orme-Zavaleta, PhD
Principal Deputy Assistant Administrator for Science
Office of Research and Development
US Environmental Protection Agency

DC 202-564-6620
Cell Ex. 6 Personal Privacy (PP)

From: Jordan, Deborah <Jordan.Deborah@epa.gov>
Sent: Tuesday, June 16, 2020 6:18 PM
To: Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>
Subject: RE: ORD role in Phase 3(b)?

Makes good sense. It's an approach worth thinking about. Thank you.

Deborah Jordan
Deputy Regional Administrator
U.S. EPA Region 9 / Pacific Southwest
75 Hawthorne Street (ORA)
San Francisco, CA 94105
415-972-3133

From: Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>
Sent: Tuesday, June 16, 2020 2:18 PM
To: Jordan, Deborah <Jordan.Deborah@epa.gov>
Subject: RE: ORD role in Phase 3(b)?

Thanks for the note Deb. Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Jennifer Orme-Zavaleta, PhD
Principal Deputy Assistant Administrator for Science
Office of Research and Development
US Environmental Protection Agency

DC 202-564-6620
Cell Ex. 6 Personal Privacy (PP)

From: Jordan, Deborah <Jordan.Deborah@epa.gov>
Sent: Tuesday, June 16, 2020 5:02 PM
To: Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>
Subject: ORD role in Phase 3(b)?

Hi Jennifer,

I've been thinking that Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Thanks so much.

Deb.

Deborah Jordan
Deputy Regional Administrator

U.S. EPA Region 9 / Pacific Southwest
75 Hawthorne Street (ORA)
San Francisco, CA 94105
415-972-3133

Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 6/22/2020 6:41:12 PM
To: Newton, Cheryl [Newton.Cheryl@epa.gov]; Szaro, Deb [Szaro.Deb@epa.gov]; Packard, Elise [Packard.Elise@epa.gov]; Shaw, Betsy [Shaw.Betsy@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Kamen, Mara [kamen.mara@epa.gov]
Subject: RE: R5 - Phase 3

I thought it would be good to categorize things. Here are the categories I have so far

Ex. 5 Deliberative Process (DP)

From: Newton, Cheryl <Newton.Cheryl@epa.gov>
Sent: Monday, June 22, 2020 2:31 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Szaro, Deb <Szaro.Deb@epa.gov>; Packard, Elise <Packard.Elise@epa.gov>; Shaw, Betsy <Shaw.Betsy@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>
Subject: RE: R5 - Phase 3

Thanks Donna – To me a **Ex. 5 Deliberative Process (DP)**

Ex. 5 Deliberative Process (DP)

Look forward to our discussion. Thanks

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Monday, June 22, 2020 12:20 PM
To: Szaro, Deb <Szaro.Deb@epa.gov>; Newton, Cheryl <Newton.Cheryl@epa.gov>; Packard, Elise <Packard.Elise@epa.gov>; Shaw, Betsy <Shaw.Betsy@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>
Subject: FW: R5 - Phase 3

Hi – Here are Doug's thoughts. **Ex. 5 Deliberative Process (DP)**

Ex. 5 Deliberative Process (DP)

From: Benevento, Douglas <benevento.douglas@epa.gov>
Sent: Monday, June 22, 2020 10:16 AM
To: Vizian, Donna <Vizian.Donna@epa.gov>
Subject: FW: R5 - Phase 3

See my attached notes Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Thanks

From: Thiede, Kurt <thiede.kurt@epa.gov>
Sent: Monday, June 22, 2020 9:16 AM
To: Benevento, Douglas <benevento.douglas@epa.gov>
Subject: R5 - Phase 3

Doug –

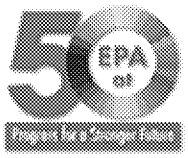
I really appreciate Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Happy to discuss,
Kurt

Kurt A. Thiede
Regional Administrator
U.S. EPA Region 5
77 W Jackson Blvd
Chicago, IL 60604
(312) 886-3000
thiede.kurt@epa.gov



Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 7/16/2020 8:37:58 PM
To: Hitchens, Lynnann [hitchens.lynnann@epa.gov]
Subject: FW: Phase 3 plan - sentence added

From: Benevento, Douglas <benevento.douglas@epa.gov>
Sent: Thursday, July 16, 2020 4:31 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>
Subject: RE: Phase 3 plan - sentence added

Ex. 5 Deliberative Process (DP)

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, July 16, 2020 4:29 PM
To: Benevento, Douglas <benevento.douglas@epa.gov>
Subject: Phase 3 plan - sentence added

Doug- we added this Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Message

From: Braxton, Marilyn [Braxton.Marilyn@epa.gov]
Sent: 6/15/2020 10:00:38 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]
CC: Hitchens, Lynnann [hitchens.lynnann@epa.gov]
Subject: RE: A though on the template
Attachments: DRAFT4.RTW MM Template_Remain in Current Phase.docx

Done, and updated in teams and SharePoint.

Ex. 5 Deliberative Process (DP)

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Monday, June 15, 2020 10:08 AM
To: Robbins, Chris <Robbins.Chris@epa.gov>
Cc: Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>; Braxton, Marilyn <Braxton.Marilyn@epa.gov>
Subject: Re: A though on the template

Thanks Chris. We should make sure offices adjust that sentence to be specific about the location. Marilyn can you add a parenthetical

> On Jun 15, 2020, at 7:12 AM, Robbins, Chris <Robbins.Chris@epa.gov> wrote:
>
> Hi Donna and Lynnann,

Ex. 5 Deliberative Process (DP)

Thanks,

Chris

Christopher S. Robbins
Deputy Assistant Administrator for Management
Office of Research and Development
(919) 541-0605
Mobile: Ex. 6 Personal Privacy (PP)

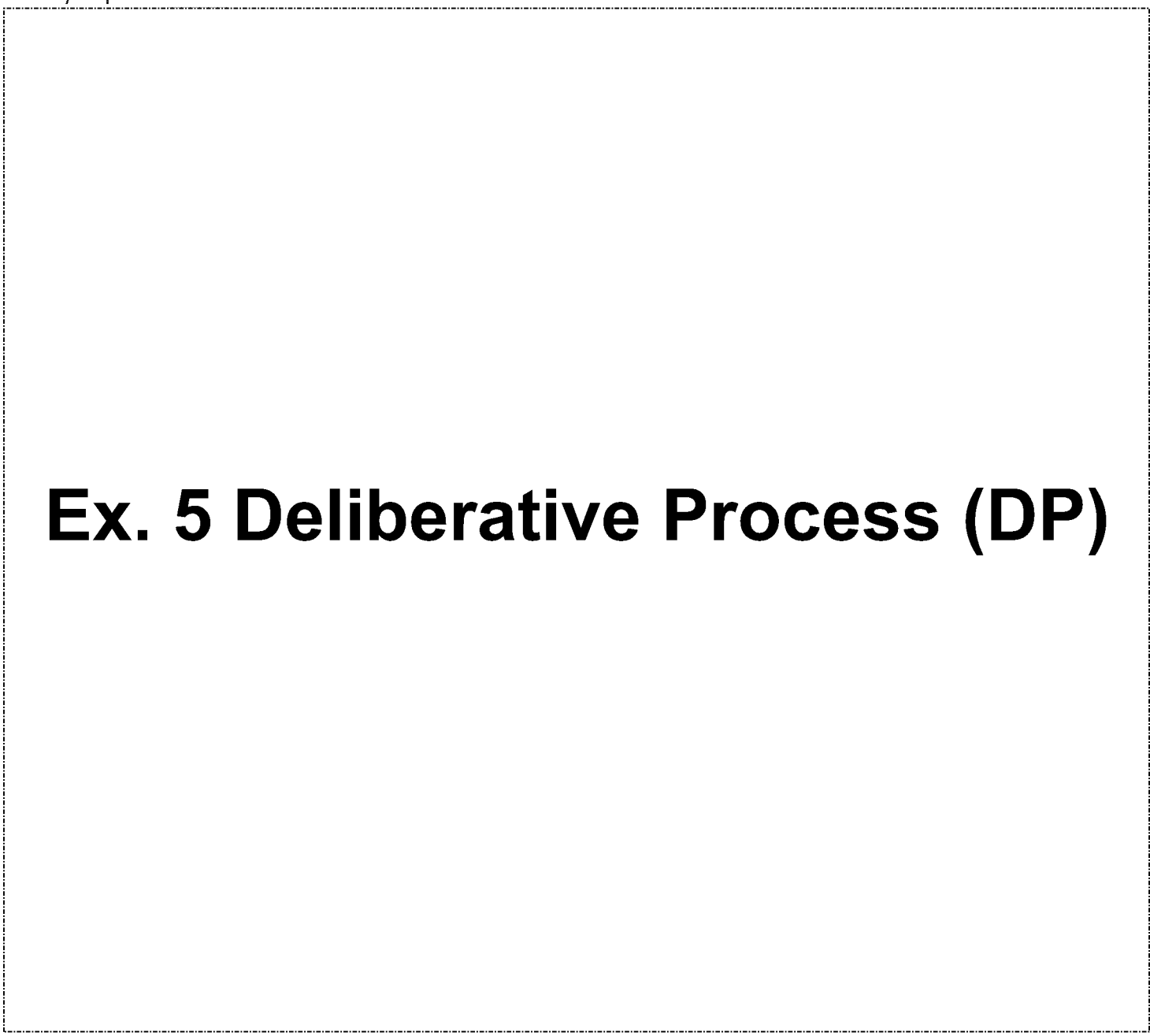
Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 6/12/2020 11:19:08 AM
To: Bell, Matthew [Bell.Matthew@epa.gov]
CC: Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Alvarado, David [alvarado.david@epa.gov]
Subject: Re: Today's Facility Update Report

Thanks Matt. I need to look at a few. Also I think we need to break the spreadsheet into 2 and we need to find a way to line it with the dashboard. Do you give Jeremy the Phase information?

On Jun 11, 2020, at 9:44 PM, Bell, Matthew <Bell.Matthew@epa.gov> wrote:

Today's updates.



Ex. 5 Deliberative Process (DP)

Sincerely,

Matthew Bell
Senior Advisor
Office of Mission Support
U.S. Environmental Protection Agency
(202)564-3282

From: Bell, Matthew
Sent: Wednesday, June 10, 2020 4:34 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Cc: Alvarado, David <alvarado.david@epa.gov>
Subject: Today's Facility Update Report

Today's updates. Let me know if there is an issue.

Additions/Edits

Facility	Status	Date
Missoula CID	Phase1 (correction)	June 6
Wheeling WV	Cleaning	May 29
Wheeling WV	Phase 1	June 9
Indianapolis CID (Market Tower)	Phase 1	June 6

Removals

Facility	Status
Washington Field Office	Removed Phase 2 date
San Diego Border	Removed Closure Entry

Sincerely,

Matthew Bell
Senior Advisor
Office of Mission Support
U.S. Environmental Protection Agency
(202)564-3282

Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 6/18/2020 2:42:43 AM
To: Hitchens, Lynnann [hitchens.lynnann@epa.gov]
Subject: FW: Facility Status Update
Attachments: Facility Status Update_06-17-2020.xlsx; Facility Status Update with Phases_06-17-2020.xlsx

Cincy is gone. Dc still there.

From: Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>
Sent: Wednesday, June 17, 2020 9:51 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>
Subject: FW: Facility Status Update

Here we are. The new table is close and will need some further sorting. Both are included. Note the off line link to the dashboard. DRAs and DAAs wont be able to access just yet. We should be able to tho. Take a look and we can talk further in the am

Jennifer Orme-Zavaleta, PhD
Principal Deputy Assistant Administrator for Science
Office of Research and Development
US Environmental Protection Agency

DC 202-564-6620
Cell Ex. 6 Personal Privacy (PP)

From: Baxter, Lisa <Baxter.Lisa@epa.gov>
Sent: Wednesday, June 17, 2020 9:41 PM
To: Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>
Cc: Cascio, Wayne <Cascio.Wayne@epa.gov>
Subject: Facility Status Update

Good Evening Jennifer,

Attached are the 2 spreadsheets, one with all of the criteria (Facility Status Update_06-17-2020), and one that focuses on criteria II and the phases (Facility Status Update with Phases_06-17-2020).

A few things to note:

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

I am happy to dig into this more tomorrow if needed.

Lisa

Lisa Baxter, S.M., Sc.D.
Division Director for the Public Health and Environmental Systems Division
U.S. Environmental Protection Agency | Office of Research and Development| Center for Public Health and Environmental Assessment
109 T.W. Alexander Drive, MC: D-143-02 | Research Triangle Park, NC 27709 |B142C|
Office: 919.541.0672
Cell: Ex. 6 Personal Privacy (PP)
baxter.lisa@epa.gov

Message

From: Braxton, Marilyn [Braxton.Marilyn@epa.gov]
Sent: 6/18/2020 10:07:35 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
CC: Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]
Subject: RE: need HQ mailer from me to enter phase 1
Attachments: HQ Phase 1 MM_6-17-2020 (002).docx; HQ-Dashboard-home_06-17-2020.PNG; HQ-Dashboard-CII_06-17-2020.PNG

Yes, attached. I also made Lynnann's edit. If you're ok with the local and mask language, Ex. 5 Deliberative Process (DP) Ex. 5 Deliberative Process (DP) The dashboard images are also attached.

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, June 18, 2020 6:05 PM
To: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Cc: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: need HQ mailer from me to enter phase 1

Do we have the charts to attach?

From: Braxton, Marilyn <Braxton.Marilyn@epa.gov>
Sent: Thursday, June 18, 2020 5:25 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Cc: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: need HQ mailer from me to enter phase 1

Ex. 5 Deliberative Process (DP) Latest version is attached

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, June 18, 2020 5:23 PM
To: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Cc: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: need HQ mailer from me to enter phase 1

Is this the latest?

From: Braxton, Marilyn <Braxton.Marilyn@epa.gov>
Sent: Thursday, June 18, 2020 4:26 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Cc: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: need HQ mailer from me to enter phase 1

Edited Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, June 18, 2020 3:09 PM
To: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Cc: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: need HQ mailer from me to enter phase 1

Edits and a few questions in the attached

From: Braxton, Marilyn <Braxton.Marilyn@epa.gov>
Sent: Thursday, June 18, 2020 1:51 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Cc: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: need HQ mailer from me to enter phase 1

Sorry…revision attached

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: Braxton, Marilyn
Sent: Thursday, June 18, 2020 1:22 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>
Cc: Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: need HQ mailer from me to enter phase 1

The draft for HQ is attached. Just need our snippet

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, June 18, 2020 1:14 PM
To: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: need HQ mailer from me to enter phase 1

Message

From: Shaw, Betsy [Shaw.Betsy@epa.gov]
Sent: 6/16/2020 8:22:49 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Benevento, Douglas [benevento.douglas@epa.gov]
CC: Idsal, Anne [idsal.anne@epa.gov]
Subject: OAR Reopening Plan for Review and Approval
Attachments: OAR General Reopen Plan Review Draft 6 16 2020 .docx; OAR NVFEL Reopen Plan to OMS 6 16 20.docx; OAR NAREL Reopen Plan to OMS 6 16 2020.docx; OAR NCRFO Reopen Plan to OMS 6 16 20.docx

Hi Donna, Lynnann and Doug,

Attached please find the draft Office of Air and Radiation Reopening plan for your review and approval. Please note that the plan focuses on Phases 1 and 2 of the reopening process and is comprised of four component parts.

The first part, entitled "OAR General Reopen Plan," is an umbrella document that lays out generally applicable guidelines for all of the five locations where OAR employees work. The umbrella document explains that employees in who work in the Federal Triangle Complex in Washington, D.C. and Research Triangle Park, NC will largely fall under the campus-wide reopening plans developed by the Office of Mission Support (OMS). Subsequent sections lay out expectations and procedures specific to the National Vehicle and Fuels Emissions Laboratory (NVFEL) in Ann Arbor, MI, the National Analytical Radiation Environmental Laboratory in Montgomery, AL, and the National Center for Radiation Field Operations (NCRFO) in Las Vegas, NV, respectively.

Our thought is Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

We welcome your feedback and/or thumbs up to proceed.

Thanks,

Betsy

Message

From: Caro, Vique [Caro.Vique@epa.gov]
Sent: 7/17/2020 1:27:38 PM
To: CI-ALL [CI-ALL@EPA.GOV]
Subject: Cincinnati Facility Status Update

Colleagues,

Administrator Wheeler has emphasized that our plan for a phased return to our offices is both measured and deliberate to minimize risk to your health. Our plan provides for a "rolling reopening," so each facility will proceed through the phases after a thorough review of health information that comprises the gating criteria outlined in the Opening Up America Again Guidance, while keeping in mind any city, state, or county requirements as well.

During the review of 14-day trend data this week for the Cincinnati, our Agency experts determined that the gating criteria to enter Phase 1 were not met. Therefore, it was decided to not move to Phase 1. Due to the prolonged time we have remained in the cleaning closure phase (also known as Phase 0), and realizing that there is still critical work that needs to be done in the facility, starting Monday we will be entering a modified Phase 0. During this modified Phase 0, individuals who need to enter the facility still must go through their supervisor. However, individuals will no longer need to be escorted and more janitorial staff will be brought onboard to clean high-touch areas.

The Cincinnati office space remains closed to ensure that any possible virus in our facilities is rendered inactive prior to employees' return. Any spaces that need to be accessed during the extended closure will be cleaned and disinfected before entering Phase 1. We will continue to follow our own guidance on cleaning and disinfecting, which we developed with the Centers for Disease Control and Prevention (CDC), throughout this process. Please contact your supervisor should you need access to a facility during the extended closure.

As a reminder, the Office of Research and Development updates the data weekly by Thursday, and you can review the data and trends on the Agency dashboard for additional information. (To access the dashboard, select "Your ArcGIS organization's URL" and enter "EPA" in the box for "Your ArcGIS organization's URL," click continue, select EPA Enterprise and login with your EPA credentials.)

Your health and safety are our top priority. We will reevaluate the public health data next week and continue to keep you updated on the status of our locations.

Vique Caro
Office Director
Office of Administration and Resources Management Cincinnati
US Environmental Protection Agency
Main Office: 513-569-7910
Desk Phone: 513-569-7912
Cell: Ex. 6 Personal Privacy (PP)
email: caro.vique@epa.gov

Message

From: Braxton, Marilyn [Braxton.Marilyn@epa.gov]
Sent: 6/18/2020 9:24:30 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
CC: Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]
Subject: RE: need HQ mailer from me to enter phase 1
Attachments: HQ Phase 1 MM_6-17-2020 (002).docx

David had 1 more edit to the travel paragraph. Latest version is attached

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, June 18, 2020 5:23 PM
To: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Cc: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: need HQ mailer from me to enter phase 1

Is this the latest?

From: Braxton, Marilyn <Braxton.Marilyn@epa.gov>
Sent: Thursday, June 18, 2020 4:26 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Cc: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: need HQ mailer from me to enter phase 1

Edited (including Larry's update) with a few things to note:

- Ex. 5 Deliberative Process (DP)
- DC Mayor will announce phase 2 date tomorrow. The language included comes from the DC site that we link in the MM

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, June 18, 2020 3:09 PM
To: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Cc: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: need HQ mailer from me to enter phase 1

Edits and a few questions in the attached

From: Braxton, Marilyn <Braxton.Marilyn@epa.gov>
Sent: Thursday, June 18, 2020 1:51 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>

Cc: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: need HQ mailer from me to enter phase 1

Sorry…revision attached

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: Braxton, Marilyn
Sent: Thursday, June 18, 2020 1:22 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>
Cc: Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: need HQ mailer from me to enter phase 1

The draft for HQ is attached. Just need our snippet

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, June 18, 2020 1:14 PM
To: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: need HQ mailer from me to enter phase 1

Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 6/10/2020 12:18:49 PM
To: Benevento, Douglas [benevento.douglas@epa.gov]; Garvey, Megan [garvey.megan@epa.gov]; Grantham, Nancy [Grantham.Nancy@epa.gov]; Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]; Zeckman, David [zeckman.david@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Dunlap, David [dunlap.david@epa.gov]
Subject: Procedure Question

Doug –

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Message

From: Braxton, Marilyn [Braxton.Marilyn@epa.gov]
Sent: 7/15/2020 9:50:41 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
CC: Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]
Subject: TPs >> RE: Phase 3 Reopening Plan
Attachments: P3 Plan TPs_draft_v1.docx

The draft senior leadership talking points are attached for your review.

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Wednesday, July 15, 2020 1:47 PM
To: Leadership_Assistant_Administrators <Leadership_Assistant_Administrators@epa.gov>; Leadership_Regional_Administrators <Leadership_Regional_Administrators@epa.gov>; Leadership_Deputy_Regional_Administrators <Leadership_Deputy_Regional_Administrators@epa.gov>; Leadership_Deputy_Assistant_Administrators <Leadership_Deputy_Assistant_Administrators@epa.gov>; Leadership_Associate_Administrators <Leadership_Associate_Administrators@epa.gov>
Subject: Phase 3 Reopening Plan

Hi Everyone,

Ex. 5 Deliberative Process (DP)

Thanks
Donna

Message

From: Kamen, Mara [kamen.mara@epa.gov]
Sent: 6/10/2020 4:57:19 PM
To: Hitchens, Lynnann [hitchens.lynnann@epa.gov]
CC: Braxton, Marilyn [Braxton.Marilyn@epa.gov]; Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]; Hart, Debbi [Hart.Debbi@epa.gov]; Jackson, Yvette [Jackson.Yvette@epa.gov]; Patterson, Nicole [Patterson.Nicole@epa.gov]
Subject: RE: Final draft of the Headquarters Return to Work Plan
Attachments: Return to the Workplace_HQ Draft 6 10 2020 VS1.docx

With my edits and comments. Thank you for the opportunity to review.
Mara

From: Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Sent: Wednesday, June 10, 2020 10:59 AM
To: Bertrand, Charlotte <Bertrand.Charlotte@epa.gov>; Best-Wong, Benita <Best-Wong.Benita@epa.gov>; Bloom, David <Bloom.David@epa.gov>; Breen, Barry <Breen.Barry@epa.gov>; Carpenter, Wesley <Carpenter.Wesley@epa.gov>; Grantham, Nancy <Grantham.Nancy@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Kadeli, Lek <Kadeli.Lek@epa.gov>; Kudarauskas, Paul <Kudarauskas.Paul@epa.gov>; Nishida, Jane <Nishida.Jane@epa.gov>; Noga, Vaughn <Noga.Vaughn@EPA.GOV>; Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>; Packard, Elise <Packard.Elise@epa.gov>; Payne, James <payne.james@epa.gov>; Richardson, RobinH <Richardson.RobinH@epa.gov>; Robbins, Chris <Robbins.Chris@epa.gov>; Shaw, Betsy <Shaw.Betsy@epa.gov>; Sheehan, Charles <Sheehan.Charles@epa.gov>; Shields, Edward <Shields.Ed@epa.gov>; Stanich, Ted <Stanich.Ted@epa.gov>; Starfield, Lawrence <Starfield.Lawrence@epa.gov>; Terris, Carol <Terris.Carol@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Wooden-Aguilar, Helena <Wooden-Aguilar.Helena@epa.gov>
Cc: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Jackson, Yvette <Jackson.Yvette@epa.gov>; Daniels, Alva <daniels.alva@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Castro, Denise <Castro.Denise@epa.gov>; Jefferson, Gayle <Jefferson.Gayle@epa.gov>; Coogan, Daniel <Coogan.Daniel@epa.gov>
Subject: Final draft of the Headquarters Return to Work Plan

Folks – I've attached the FINAL DRAFT

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Thanks,

Lynnann

Lynnann Hitchens
Acting Deputy Assistant Administrator for
Administration and Resources Management
Office of Mission Support
US EPA
P: 202-564-3184
M: Ex. 6 Personal Privacy (PP)

Message

From: Szaro, Deb [Szaro.Deb@epa.gov]
Sent: 6/4/2020 8:00:54 PM
To: Benevento, Douglas [benevento.douglas@epa.gov]; Vizian, Donna [Vizian.Donna@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
CC: Johnson, Arthur [Johnson.Arthur@epa.gov]; Deziel, Dennis [Deziel.Dennis@epa.gov]
Subject: Final Draft Region 1 COVID-19 Reconstitution Plan
Attachments: Final Draft R1 COVID-19 Reconstitution Plan.docx

Good Afternoon,

Attached is Region 1's Final Draft Reconstitution Plan. We look forward to receiving any feedback you might have.

Deb

Message

From: Helm, Arron [Helm.Arron@epa.gov]
Sent: 5/28/2020 6:32:05 PM
To: Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Vizian, Donna [Vizian.Donna@epa.gov]
CC: Caro, Vique [Caro.Vique@epa.gov]; Jackson, Yvette [Jackson.Yvette@epa.gov]
Subject: FW: RTP Reopening Plan - Draft
Attachments: DRAFT - EPA RTP Return to Workplace.docx

FYI – Here is our revised and updated closure and Phase 1, Phase 2 reopening plan.

At what point do we have this shared with the Union? Once we get notice from HQ to move to closure period?

Message

From: Kamen, Mara [kamen.mara@epa.gov]
Sent: 5/20/2020 12:52:52 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Braxton, Marilyn [Braxton.Marilyn@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Patterson, Nicole [Patterson.Nicole@epa.gov]; Hart, Debbi [Hart.Debbi@epa.gov]; Hunt, Loretta [Hunt.Loretta@epa.gov]; Bell, Matthew [Bell.Matthew@epa.gov]; Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]
Subject: RE: Reopening plan
Attachments: Returning to the Office Discussion Notes - final.docx

So you all have it, attached are the FLAGs questions. These are all issues we've identified previously, just in one place.

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Wednesday, May 20, 2020 8:42 AM
To: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>; Bell, Matthew <Bell.Matthew@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: FW: Reopening plan

From: Vizian, Donna
Sent: Tuesday, May 19, 2020 6:56 PM
To: Gamache, Christopher D. EOP/OMB <Christopher_D_Gamache@omb.eop.gov>; Hickey, Mike J. EOP/OMB (Michael_Hickey@omb.eop.gov) <Michael_Hickey@omb.eop.gov>
Subject: Reopening plan

Hi Mike and Chris,

Attached is our draft plan Ex. 5 Deliberative Process (DP) Can you help me get this to the right place for review. Please call if you have questions. Ex. 6 Personal Privacy (PP) thanks

Message

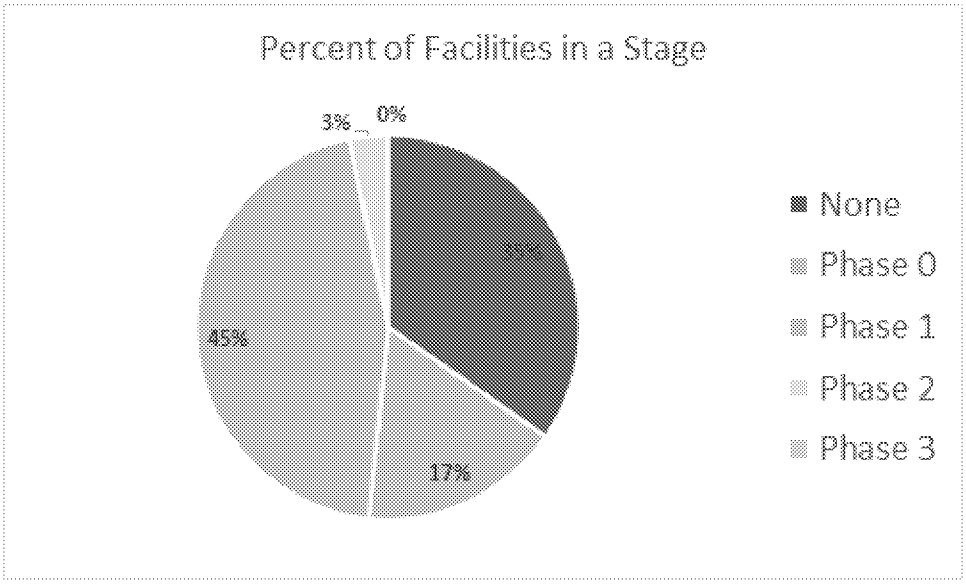
From: Bell, Matthew [Bell.Matthew@epa.gov]
Sent: 7/21/2020 7:29:06 PM
To: Benevento, Douglas [benevento.douglas@epa.gov]; Vizian, Donna [Vizian.Donna@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
CC: Braxton, Marilyn [Braxton.Marilyn@epa.gov]; Alvarado, David [alvarado.david@epa.gov]
Subject: Federal Facility Entry Report
Attachments: Facility Entry Log 7.21.20.xlsx

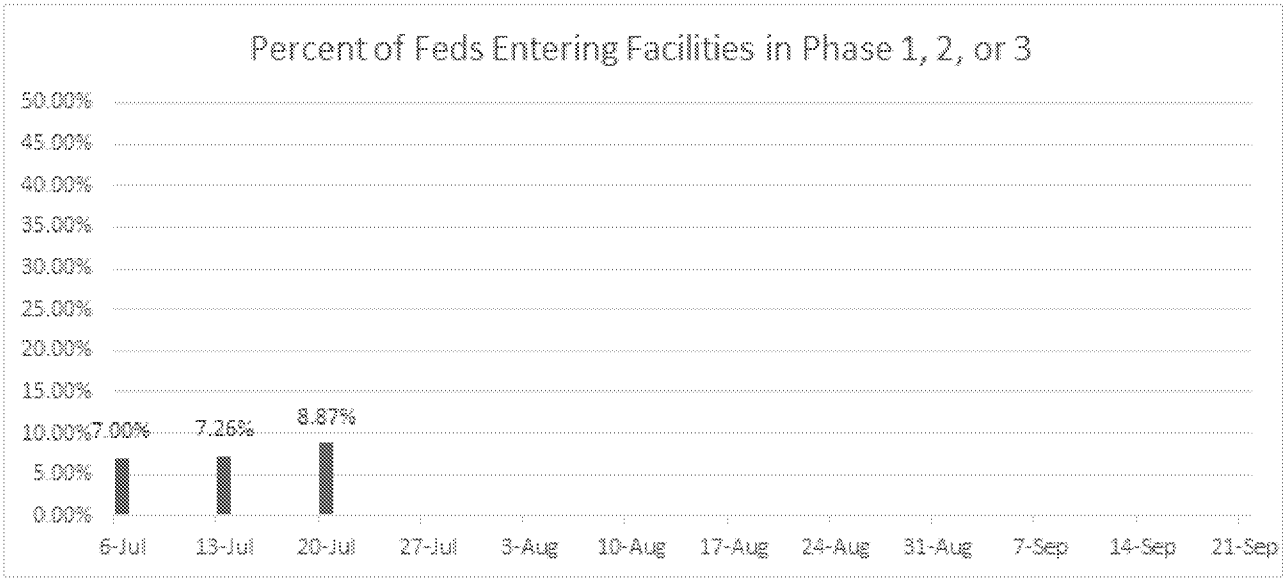
Good Afternoon,

Attached is the entry count of federal employees at EPA facilities.

About the Log:

- Reporting is being performed on facilities in Phase 1, 2, or 3.
- Reporting is capturing the number of [different] federal employees who have entered the facility during the week (for example, 1 person entering the facility Monday – Friday only counts as 1 individual, not 5).
- Row 3 shows what percentage of federal employees in those locations have entered the facilities. These calculations will change based on the filtering being used (for example, if you filter to see only Phase 2 facilities, it will show those totals and calculations)
- A color identifier for phases is included in the spreadsheet to help identify entry trends as it relates to Phase.





Matthew Bell
Senior Advisor|Office of Mission Support
U.S. Environmental Protection Agency
(202)564-3282

Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 5/20/2020 12:41:40 PM
To: Braxton, Marilyn [Braxton.Marilyn@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Patterson, Nicole [Patterson.Nicole@epa.gov]; Kamen, Mara [kamen.mara@epa.gov]; Hart, Debbi [Hart.Debbi@epa.gov]; Hunt, Loretta [Hunt.Loretta@epa.gov]; Bell, Matthew [Bell.Matthew@epa.gov]; Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]
Subject: FW: Reopening plan
Attachments: Return to the Workplace Guidance_5.19 2020_Final Draft.docx

From: Vizian, Donna
Sent: Tuesday, May 19, 2020 6:56 PM
To: Gamache, Christopher D. EOP/OMB <Christopher_D_Gamache@omb.eop.gov>; Hickey, Mike J. EOP/OMB (Michael_Hickey@omb.eop.gov) <Michael_Hickey@omb.eop.gov>
Subject: Reopening plan

Hi Mike and Chris,

Attached is our draft plan. We are moving to open a few our office next week Ex. 5 Deliberative Process (DP) Can you help me get this to the right place for review. Please call if you have questions. Ex. 6 Personal Privacy (PP) thanks

Message

From: Braxton, Marilyn [Braxton.Marilyn@epa.gov]
Sent: 5/20/2020 8:36:04 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]
Subject: Gaiting Criteria/ORD Tool FAQs

ORD reviewed and OK'd questions 2 and 3 below. (I just wrote Q1 since I think we'll be asked) to go in the returning to the workplace FAQ site.

Q. What are the gating criteria?

Ex. 5 Deliberative Process (DP)

Q. What data is the Agency using to making the determination to reopen EPA facilities?

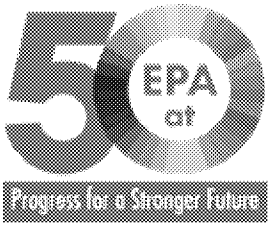
Ex. 5 Deliberative Process (DP)

Q. How often is the criteria to determine if a location opens or moves to a different phase evaluated?

Ex. 5 Deliberative Process (DP)

Regards,
Marilyn

Marilyn A. Braxton, Chief of Staff
****
Office of Mission Support, US Environmental Protection Agency
braxton.marilyn@epa.gov | 202-564-8192 | Ex. 6 Personal Privacy (PP) (mobile) | WJC North 3330C
Mailing Address: 1200 Pennsylvania Avenue, NW, Washington, DC 20460, Mail Code: 3101A
(Hours: 8:30am – 6:00pm, compressed 2nd Friday)


50
EPA
at
Progress for a Stronger Future

Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 5/28/2020 4:36:39 PM
To: Bell, Matthew [Bell.Matthew@epa.gov]
CC: Braxton, Marilyn [Braxton.Marilyn@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
Subject: RE: more info needed

Awesome - thanks

From: Bell, Matthew <Bell.Matthew@epa.gov>
Sent: Thursday, May 28, 2020 12:30 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>
Cc: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Subject: RE: more info needed

Donna,

See below. Dallas was hard to find solid info but it sounds like they were aligning themselves with the state overall.

Not to deflect the work but I just found this that will be helpful in general. https://abcnews.go.com/Business/states-coronavirus-reopening-plan/story?id=70565409

R8	**Colorado** Current in Phase 2. Businesses opening (including restaurants and bars) in a limited capacity on May 27. In Phase 1, business opened at 50% capacity on May 1, and non-critical offices were allowed to reopen on May 4. Camps to reopen on June 1. Distancing still expected and people encouraged to stay home, but not requried. https://covid19.colorado.gov/safer-at-home	**Denver County** On May 9 many businesses re-opened at 50% capacity and distancing. Still urged to stay home. Eat-in restaurants, theaters, venues, pools, etc. are still closed. New city operating procedures began on May 11 with nine types remaining closed (including city and county office buildings). https://www.denvergov.org/content/denvergov/en/covid-19/recovery-guidance/city-services-facilities.html
R6	**Texas** Phase 1 started on May 1, opening retail, restaurants, theaters, etc. at 25% capacity and distancing. Phase 2 started on May 18 and on May 22 an Order was announced to open most other businesses (except pools and other interactive venues). Distancing rules still apply and capacity expanded to 50%. https://www.dshs.state.tx.us/coronavirus/opentexas.aspx	**Dallas** Dallas Admin building is closed until further notice. Phase 1 began on May 1 allowing many business to open at 25-50% capacity while practicing distancing. Local govt's may reopen. Phase 2 (not announced) will allow restaurant and bars to reopen (50/25%)
R1	**Massachusetts** Phase 1 started on May 18. Phases to last at least 3 weeks. Gatherings should still be <10 people. Essential businesses/manufacturing/construction can continue will limitation. Office, lab, etc. space can proceed with limitations. Boston to follow on June 1. https://www.mass.gov/info-details/reopening-four-phase-approach	**Boston** Following the state plan in large part. However, a Public Health Advisory for everyone to stay at home remains in effect. To allow office space opening on June 1. City hall will only be open to the public on Tuesdays and Fridays.

		https://www.boston.gov/news/coronavirus-disease-covid-19-boston	

Sincerely,

Matthew Bell
Senior Advisor
Office of Mission Support
U.S. Environmental Protection Agency
(202)564-3282

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, May 28, 2020 10:44 AM
To: Bell, Matthew <Bell.Matthew@epa.gov>
Cc: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Subject: more info needed

Matt,

Can you also pull the information for:

R8 – CO, Denver County and Jefferson County
R6 – TX and Dallas
R1 – MA, Boston, RI, NH,

thanks

Message

From: Chu, Ed [Chu.Ed@epa.gov]
Sent: 5/19/2020 3:18:16 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
Subject: RE: Final Review - Return to Work Guidance

Donna and Lynnann,

Thanks for the opportunity for a final review. Just a couple of remaining issues for consideration:

Ex. 5 Deliberative Process (DP)

Edward H. Chu | Deputy Regional Administrator
U.S. Environmental Protection Agency
Region 7 (Kansas, Missouri, Nebraska, Iowa & Nine Tribes)
(913) 551-7333
epa.gov | epa.gov/region7

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Monday, May 18, 2020 3:35 PM
To: Leadership_Assistant_Administrators <Leadership_Assistant_Administrators@epa.gov>; Leadership_Deputy_Assistant_Administrators <Leadership_Deputy_Assistant_Administrators@epa.gov>; Leadership_Associate_Administrators <Leadership_Associate_Administrators@epa.gov>; Leadership_Regional_Administrators <Leadership_Regional_Administrators@epa.gov>; Leadership_Deputy_Regional_Administrators <Leadership_Deputy_Regional_Administrators@epa.gov>
Cc: Garvey, Megan <garvey.megan@epa.gov>
Subject: Final Review - Return to Work Guidance

Hi Everyone,

As Doug mentioned today at Senior Staff, we are providing the final draft of our Returning to Work Guidance for one last review. Please send any comments to Lynnann Hitchens and me by noon tomorrow. If you have any questions, please feel free to call.

Best,
Donna

Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 5/19/2020 11:41:11 PM
To: Grantham, Nancy [Grantham.Nancy@epa.gov]; Benevento, Douglas [benevento.douglas@epa.gov]; Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]
CC: Hitchens, Lynnann [hitchens.lynnann@epa.gov]
Subject: RE: Draft MM
Attachments: Draft Reopening Msg_vs2.docx

Use this version. I left out R4

From: Vizian, Donna
Sent: Tuesday, May 19, 2020 7:30 PM
To: Grantham, Nancy <Grantham.Nancy@epa.gov>; Benevento, Douglas <benevento.douglas@epa.gov>; Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>
Cc: Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Subject: Draft MM

Here is the draft. It may be a bit long but I think it is a good start.

Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 5/19/2020 11:29:58 PM
To: Grantham, Nancy [Grantham.Nancy@epa.gov]; Benevento, Douglas [benevento.douglas@epa.gov]; Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]
CC: Hitchens, Lynnann [hitchens.lynnann@epa.gov]
Subject: Draft MM
Attachments: Draft Reopening Msg_vs2.docx

Here is the draft. It may be a bit long but I think it is a good start.

Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 5/25/2020 4:36:35 PM
To: Benevento, Douglas [benevento.douglas@epa.gov]
CC: Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Garvey, Megan [garvey.megan@epa.gov]
Subject: Reopening Plan to post
Attachments: Return to the Workplace Plan (posting)_May 25 2020.docx

Doug – here is the draft plan. It has been reviewed by Nancy and Andrea. I highlighted the areas that I want to make sure you are ok with. thanks

Message

From: Bell, Matthew [Bell.Matthew@epa.gov]
Sent: 6/3/2020 6:47:06 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
Subject: Facility Tracking
Attachments: Return to the Workplace_Snr Leader Guidance.pdf

FYI, I figured out how to make Excel automatically update the OMB reporting category status whenever we enter dates in the phases. Pretty cool and should save tons of time.
Let me know if you change any of the designations below based on the guidance because I'll have to update the spreadsheet formulas. I took a stab at updating, however, it appears as though the phases below are all one behind what document says.

Reference highlighted portions of pages 4 & 5 of the attached.

Status of:	Stay-at-home	Cleaning Phase	Phase 1	Phase 2	Phase 3	Normal Operations
Telework	Mandatory	Mandatory	~~Maximum~~ Expanded (Guidance says *COOP and Maximum Telework lifted*)	~~Maximum~~ Expanded	~~Expanded~~ Normal	Normal
Facility	Closed	Closed	~~Mostly Closed~~ Mostly Open	~~Mostly Closed~~ Mostly Open	Fully Open	Fully Open
Travel	Essential	Essential	Essential	~~Essential~~ Normal	~~Restricted~~ Normal	Normal

Telework	**Facility**	**Travel**
- Mandatory - Maximum - Expanded/Flexible - Normal - NA	- Fully Open - Mostly Open - Mostly Closed - Closed - NA	- Essential Only - Restricted - Normal

Sincerely,

Matthew Bell
Senior Advisor
Office of Mission Support
U.S. Environmental Protection Agency
(202)564-3282

Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 6/9/2020 8:32:41 PM
To: Hitchens, Lynnann [hitchens.lynnann@epa.gov]
Subject: FW: Any feedback on our plan?
Attachments: R5 DRAFT Reconstitution Plan - 6.4.2020 v2.docx

From: Vizian, Donna
Sent: Friday, June 05, 2020 2:45 PM
To: Newton, Cheryl <Newton.Cheryl@epa.gov>
Cc: Sanders, Amy <Sanders.Amy@epa.gov>
Subject: RE: Any feedback on our plan?

Cheryl and Amy – good job on the plan. I have just a few suggestions.

Enjoy the weekend

From: Newton, Cheryl <Newton.Cheryl@epa.gov>
Sent: Thursday, June 04, 2020 5:00 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>
Cc: Sanders, Amy <Sanders.Amy@epa.gov>
Subject: Any feedback on our plan?

Hi Donna – Here is our slightly updated plan. Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Thanks

Cheryl L. Newton
Deputy Regional Administrator, R5

Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 5/19/2020 8:57:29 PM
To: Benevento, Douglas [benevento.douglas@epa.gov]
CC: Garvey, Megan [garvey.megan@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
Subject: Re: RTW Guidance

Ok. Please feel free to call later

On May 19, 2020, at 2:40 PM, Benevento, Douglas <benevento.douglas@epa.gov> wrote:

Thanks Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

I may have to get back to you in the morning on this.

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Tuesday, May 19, 2020 4:20 PM
To: Benevento, Douglas <benevento.douglas@epa.gov>
Cc: Garvey, Megan <garvey.megan@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Subject: RTW Guidance

Doug,

Ex. 5 Deliberative Process (DP)

The first attachment is the clean version, the second is the redline document. I also included the table of comments.

thanks

Message

From: Best-Wong, Benita [Best-Wong.Benita@epa.gov]
Sent: 5/12/2020 4:39:44 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
CC: Bertrand, Charlotte [Bertrand.Charlotte@epa.gov]
Subject: RE: Returning to the Workplace Draft Guidance
Attachments: Return to the Workplace Guidance final draft May 8_ADOWcomments.docx; FACILITY RECONSITUTION CHECKLIST_05082020 clean.OWcomments.docx

Donna and Lynnann- We appreciate the opportunity to provide comments on the Agency's Returning to Workplace Draft Guidance. Below are some general comments. Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Regards,
Benita

Benita Best-Wong
Deputy Assistant Administrator

Office of Water
US EPA
1200 Pennsylvania Avenue, NW
Washington, DC 20460
202-566-1159

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Friday, May 08, 2020 6:39 PM
To: Benevento, Douglas <benevento.douglas@epa.gov>; Bloom, David <Bloom.David@epa.gov>; Bodine, Susan <bodine.susan@epa.gov>; Carpenter, Wesley <Carpenter.Wesley@epa.gov>; Darwin, Henry <darwin.henry@epa.gov>; Dunn, Alexandra <dunn.alexandra@epa.gov>; Garvey, Megan <garvey.megan@epa.gov>; Gunasekara, Mandy <gunasekara.Mandy@epa.gov>; Idsal, Anne <idsal.anne@epa.gov>; Leopold, Matt (OGC) <Leopold.Matt@epa.gov>; McIntosh, Chad <mcintosh.chad@epa.gov>; Molina, Michael <molina.michael@epa.gov>; O'Donnell, Sean <ODonnell.Sean@epa.gov>; Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>; Ross, David P <ross.davidp@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Wheeler, Andrew <wheeler.andrew@epa.gov>; Wright, Peter <wright.peter@epa.gov>; Leadership_Regional_Administrators <Leadership_Regional_Administrators@epa.gov>; Leadership_Deputy_Assistant_Administrators <Leadership_Deputy_Assistant_Administrators@epa.gov>; Leadership_Associate_Administrators <Leadership_Associate_Administrators@epa.gov>; Leadership_Deputy_Regional_Administrators <Leadership_Deputy_Regional_Administrators@epa.gov>
Cc: Garvey, Megan <garvey.megan@epa.gov>; Zeckman, David <zeckman.david@epa.gov>
Subject: Returning to the Workplace Draft Guidance

Hi Everyone,

Ex. 5 Deliberative Process (DP)

Best,
Donna

Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 6/9/2020 7:07:48 PM
To: Szaro, Deb [Szaro.Deb@epa.gov]; Benevento, Douglas [benevento.douglas@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
CC: Johnson, Arthur [Johnson.Arthur@epa.gov]; Deziel, Dennis [Deziel.Dennis@epa.gov]
Subject: RE: Final Draft Region 1 COVID-19 Reconstitution Plan
Attachments: Final Draft R1 COVID-19 Reconstitution Plan.docx

Thank you Deb. The plan looks good. A few suggestions in the attached.

From: Szaro, Deb <Szaro.Deb@epa.gov>
Sent: Thursday, June 04, 2020 4:01 PM
To: Benevento, Douglas <benevento.douglas@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Cc: Johnson, Arthur <Johnson.Arthur@epa.gov>; Deziel, Dennis <Deziel.Dennis@epa.gov>
Subject: Final Draft Region 1 COVID-19 Reconstitution Plan

Good Afternoon,

Attached is Region 1's Final Draft Reconstitution Plan. We look forward to receiving any feedback you might have.

Deb

Message

From: Vizian, Donna [Vizian.Donna@epa.gov]
Sent: 6/8/2020 10:33:31 PM
To: Jordan, Deborah [Jordan.Deborah@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Benevento, Douglas [benevento.douglas@epa.gov]
CC: Busterud, John [Busterud.John@epa.gov]; Drake, Kerry [Drake.Kerry@epa.gov]
Subject: RE: Region 9 reconstitution plan
Attachments: R9 Reconstitution Plan 060620.docx

Thank you Deb. Good job, I have just a few suggestions in the document.

Best,
Donna

From: Jordan, Deborah <Jordan.Deborah@epa.gov>
Sent: Saturday, June 06, 2020 4:08 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Benevento, Douglas <benevento.douglas@epa.gov>
Cc: Busterud, John <Busterud.John@epa.gov>; Drake, Kerry <Drake.Kerry@epa.gov>
Subject: Region 9 reconstitution plan

Hi all,

Attached is Region 9's draft reconstitution plan. Please review at your convenience.

Have a great weekend!

Best,
Deb.

Deborah Jordan
Deputy Regional Administrator
U.S. EPA Region 9 / Pacific Southwest
75 Hawthorne Street (ORA)
San Francisco, CA 94105
415-972-3133

Message

From: Richardson, RobinH [Richardson.RobinH@epa.gov]
Sent: 5/12/2020 3:16:47 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]
CC: Carpenter, Wesley [Carpenter.Wesley@epa.gov]; Wooden-Aguilar, Helena [Wooden-Aguilar.Helena@epa.gov]; Grantham, Nancy [Grantham.Nancy@epa.gov]; Stanich, Ted [Stanich.Ted@epa.gov]; Kudarauskas, Paul [Kudarauskas.Paul@epa.gov]
Subject: FW: Returning to the Workplace Draft Guidance
Attachments: Return to the Workplace Guidance final draft May 8_AD WJC Comments 5-11-2020.docx; FACILITY RECONSITUTION CHECKLIST_05082020 clean WJC Comments 5-11-2020.docx; Employee Daily Self Assessment 5 8 20 WJC Comments 5-11-2020.docx; EPA COVID 19 Contact Tracing and Notification Guidance may82020 WJC Comments 5-11-2020.docx

Hi Donna & Lynnann –

Thank you for the opportunity to review and comment on the draft guidance, checklist, self-assessment and tracing and notification guidance. Attached are AO's comments provided in red-line strikeout. Below are more substantive comments for consideration. We really appreciate all the hard work that has gone into these documents.

Ex. 5 Deliberative Process (DP)

Best, Robin

Robin H Richardson
Deputy Associate Administrator
Office of Congressional and Intergovernmental Relations
U.S. Environmental Protection Agency
202-564-3358 (desk)
Ex. 6 Personal Privacy (PP) (cell)
richardson.robinh@epa.gov

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Friday, May 08, 2020 6:39 PM
To: Benevento, Douglas <benevento.douglas@epa.gov>; Bloom, David <Bloom.David@epa.gov>; Bodine, Susan <bodine.susan@epa.gov>; Carpenter, Wesley <Carpenter.Wesley@epa.gov>; Darwin, Henry <darwin.henry@epa.gov>; Dunn, Alexandra <dunn.alexandra@epa.gov>; Garvey, Megan <garvey.megan@epa.gov>; Gunasekara, Mandy <gunasekara.Mandy@epa.gov>; Idsal, Anne <idsal.anne@epa.gov>; Leopold, Matt (OGC) <Leopold.Matt@epa.gov>; McIntosh, Chad <mcintosh.chad@epa.gov>; Molina, Michael <molina.michael@epa.gov>; O'Donnell, Sean <ODonnell.Sean@epa.gov>; Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>; Ross, David P <ross.davidp@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Wheeler, Andrew <wheeler.andrew@epa.gov>; Wright, Peter <wright.peter@epa.gov>; Leadership_Regional_Administrators <Leadership_Regional_Administrators@epa.gov>; Leadership_Deputy_Assistant_Administrators <Leadership_Deputy_Assistant_Administrators@epa.gov>; Leadership_Associate_Administrators <Leadership_Associate_Administrators@epa.gov>; Leadership_Deputy_Regional_Administrators <Leadership_Deputy_Regional_Administrators@epa.gov>
Cc: Garvey, Megan <garvey.megan@epa.gov>; Zeckman, David <zeckman.david@epa.gov>
Subject: Returning to the Workplace Draft Guidance

Hi Everyone,

Attached please find the final draft of the Returning to the Workplace Guidance for your review and comment. This is a draft document that the Administrator will ultimately sign off on before it is sent to OMB and then implemented. We anticipate that it will be final the end of next week or the very beginning of the week after. The audience for this is the senior leadership – it is not meant for all employees or even all supervisors. We will have operational documents to accompany this once the guidance is final. A few examples are attached: Facility Checklist, Employee Daily Self-Screening Guide and Contact Tracing Guide.

Since it is draft, it is very close-hold. Please do not share it. Please send comments back to Lynnann Hitchens and me by noon (EDT) Tuesday. We would appreciate it if offices can consolidate comments.

Best,
Donna

Message

From: Jackson, Yvette [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=471286FDB21245768617020D920C6BCA-YJACKSON]
Sent: 6/22/2020 10:04:48 PM
To: HQ_Facilities_Updates [HQ_Facilities_Updates@epa.gov]
Subject: Phase 1 Begins Tuesday, June 23 – Office Operations

Tomorrow starts Phase 1 of our HQ Return to the Workplace Plan. The William Jefferson Clinton Buildings (North, South, East and West) and our offices in the Ronald Reagan Building and Potomac Yard Building will reopen. As a reminder, employees are encouraged to continue teleworking. If you choose to report to the workplace, here is what you should know:

Entering the Building

- Please self-screen by reviewing the self-assessment questionnaire, and do not enter the building if you answer yes to any of the listed questions.
- We have identified separate entry and exit areas in order to maintain and support social distancing.
    - EPA entry security screening locations will include: the main entrances of each of the four WJ Clinton buildings (North, South, East and West), RRB entrance on the side with turnstiles, and the main entrance of PY.
    - Exiting locations in the WJC Buildings will be as follows: West Employee entrance/exit (opposite RRB), East Employee entrance/exit (under the arch), the WJC North courtyard entrance/exit, and the Pennsylvania Avenue entrance/exit, and RRB on the opposite side from the turnstiles. The main entrance of PY will be marked with signage to create distinct entrance and exit areas. In the event of an emergency, all building exits will be open and accessible.
- For employees in FTC or RRB, the District of Columbia's Phase 2 guidance recommends that individuals should wear a cloth face covering when around other people who are not from your household. For those employees in PY, the Commonwealth of Virginia requires that people wear cloth face coverings when spending time in indoor public settings.

Enhanced Cleaning and Facility Operations and Maintenance

- Hand sanitizer, sanitizer wipes, and disinfectant sprays have been placed around the workplace.
- High touch surface areas will be cleaned daily, such as elevator buttons, doorknobs/handles, handrails, and light switches.
- The General Services Administration is working to ensure our buildings are properly maintained by following CDC's guidance on optimum engineering controls for the building ventilation systems.
- Employees should not congregate in areas including, but not limited to, entry and exit doors, lobbies and foyers, elevators, stairwells, corridors, restrooms, pantries, kitchen and break areas, photocopy, and printer areas.
- Signage is posted in high traffic areas like doorways, pantries, restrooms, stairwells, and elevators to serve as reminders for social distancing and markings on the floor are displayed in entrance and elevator lobbies. Signage and floor markings will be continuously evaluated and changed as needed.
- Only two people at a time are allowed in the elevators. Maximum occupancy posters are hung outside the doors.

Badge Office

- At EPA Headquarters, the following badge office operations and services will be provided by appointment only: issuance of badges for new employees, building access card issuances, PIN re-sets, damaged badge troubleshooting, key issuances and returns, badge returns for departing employees and off-boarding/employee separations.

The Agency will continue to adjust and update its guidance based on CDC recommendations as well as local guidance. We will provide you with more information as it becomes available. Below are some resources and helpful tips for employees:

HQ Return to the Workplace Plan
Self-Assessment Questionnaire
How to Protect Yourself & Others
COVID-19 intranet site
Travel Guidelines During the Phased Return to Workplaces

Message

From: Jackson, Yvette [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=471286FDB21245768617020D920C6BCA-YJACKSON]
Sent: 6/22/2020 6:49:07 PM
To: Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]; Daniels, Alva [daniels.alva@epa.gov]
Subject: RE: Facility Info for the Mass Mailer
Attachments: HQ Phase 1 MM 6-22-2020_VS2_OA ymj.docx

Hi Shakeba,

I've edited the entrance/exit location information. Let me know if you have questions.

Thanks,
Yvette

From: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Sent: Monday, June 22, 2020 2:39 PM
To: Daniels, Alva <daniels.alva@epa.gov>; Jackson, Yvette <Jackson.Yvette@epa.gov>
Subject: RE: Facility Info for the Mass Mailer
Importance: High

Hi Yvette, Attached is the massy I reference in our skype convo. This is the mass mailer Donna referenced this morning in our general. The mailer is just about done. Lynnann asked me to connect with you to make sure language is correct especially around entrance and exists. I'm not quiet sure where those locations are. Once you send me back your changes, I can send to Donna.

Thank you!

Shakeba Carter-Jenkins
Communications Director &
Senior Special Assistant
Office of Mission Support, U.S. Environmental Protection Agency
carter-jenkins.shakeba@epa.gov | 202-564-6385 | Ex. 6 Personal Privacy (PP) *(mobile) | WJC North 3330*
Mailing Address: 1200 Pennsylvania Avenue, NW, Washington, DC 20460

"I've learned you can tell a lot about a person by the way (s)he handles these three things: a rainy day, lost luggage, and tangled Christmas tree lights." Maya Angelou

From: Daniels, Alva <daniels.alva@epa.gov>
Sent: Friday, June 19, 2020 4:21 PM
To: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Cc: Jackson, Yvette <Jackson.Yvette@epa.gov>; Daniels, Alva <daniels.alva@epa.gov>
Subject: Facility Info for the Mass Mailer

Hi Shakeba-

Per my IM, the facility specific information (HQ only) is below. I've also attached the entire plan for easy reference.
Thx

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Alva E. Daniels
Acting Deputy Director

Office of Administration/OMS
U.S. Environmental Protection Agency
202/564-2661 office
Ex. 5 Deliberative Process (DP) mobile
daniels.alva@epa.gov

Message

From: Jackson, Yvette [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=471286FDB21245768617020D920C6BCA-YJACKSON]
Sent: 7/7/2020 4:51:39 PM
To: Daniels, Alva [daniels.alva@epa.gov]; Jefferson, Gayle [Jefferson.Gayle@epa.gov]
CC: Simbanin, Cynthia [Simbanin.Cynthia@epa.gov]; Stewart, Neil [Stewart.Neil@epa.gov]
Subject: RE: CDC recommendations to improve indoor ventilation?
Attachments: Phase 1 Begins Tuesday, June 23 – Office Operations

The link was in the Facilities Update sent on June 22 announcing HQ moving to Phase 1 on June 23.

From: Daniels, Alva <daniels.alva@epa.gov>
Sent: Tuesday, July 07, 2020 12:47 PM
To: Jefferson, Gayle <Jefferson.Gayle@epa.gov>; Jackson, Yvette <Jackson.Yvette@epa.gov>
Cc: Simbanin, Cynthia <Simbanin.Cynthia@epa.gov>; Stewart, Neil <Stewart.Neil@epa.gov>
Subject: RE: CDC recommendations to improve indoor ventilation?

I found it. Searching the intranet FAQ site to see if this is there.

From: Jefferson, Gayle <Jefferson.Gayle@epa.gov>
Sent: Tuesday, July 07, 2020 12:00 PM
To: Jackson, Yvette <Jackson.Yvette@epa.gov>; Daniels, Alva <daniels.alva@epa.gov>
Cc: Simbanin, Cynthia <Simbanin.Cynthia@epa.gov>; Stewart, Neil <Stewart.Neil@epa.gov>
Subject: RE: CDC recommendations to improve indoor ventilation?

I'll find what I've sent to Alva and Shakeba previously regarding HVAC.
Gayle

Gayle L. Jefferson
Director
Facilities Management and Services Division (FMSD)
OA/OARM/USEPA
Main Number: (202)564-2030
Direct Number: (202)564-1630
Cell Number: Ex. 6 Personal Privacy (PP)

From: Jackson, Yvette <Jackson.Yvette@epa.gov>
Sent: Tuesday, July 07, 2020 11:56 AM
To: Jefferson, Gayle <Jefferson.Gayle@epa.gov>; Daniels, Alva <daniels.alva@epa.gov>
Cc: Simbanin, Cynthia <Simbanin.Cynthia@epa.gov>; Stewart, Neil <Stewart.Neil@epa.gov>
Subject: RE: CDC recommendations to improve indoor ventilation?

Hi Gayle,

I believe this link was included in the Administrator's Mass Mailer two weeks ago. I'd have to find it to confirm. But, it would probably be helpful to develop a Q&A specifically for HVAC. Please develop and return to Alva and I to be uploaded to the agency COVID site. Thanks

From: Jefferson, Gayle <Jefferson.Gayle@epa.gov>
Sent: Tuesday, July 07, 2020 11:34 AM
To: Jackson, Yvette <Jackson.Yvette@epa.gov>; Daniels, Alva <daniels.alva@epa.gov>
Cc: Simbanin, Cynthia <Simbanin.Cynthia@epa.gov>; Stewart, Neil <Stewart.Neil@epa.gov>
Subject: FW: CDC recommendations to improve indoor ventilation?

Yvette:
Here's the link to GSA's internet site regarding HVAC, Cleaning, Etc. Do you think we should just add this link to the FAQs?
Gayle
https://www.gsa.gov/governmentwide-initiatives/emergency-response/returning-to-gsa-facilities/returning-to-facilities-federally-owned-building-management#3

Gayle L. Jefferson
Director
Facilities Management and Services Division (FMSD)
OA/OARM/USEPA
Main Number: (202)564-2030
Direct Number: (202)564-1630
Cell Number: Ex. 6 Personal Privacy (PP)

From: Carpenter, Wesley <Carpenter.Wesley@epa.gov>
Sent: Tuesday, July 07, 2020 10:51 AM
To: Jackson, Yvette <Jackson.Yvette@epa.gov>
Cc: Daniels, Alva <daniels.alva@epa.gov>; Jefferson, Gayle <Jefferson.Gayle@epa.gov>
Subject: CDC recommendations to improve indoor ventilation?

Yvette:

Good morning. I trust you and your family are doing well and staying safe. I am following up on a question from one of the AO staff regarding the HQs Buildings' ventilation systems. Please advise. Thanks.

Wes

From: Corona, Elizabeth <Corona.Elizabeth@epa.gov>
Sent: Tuesday, July 07, 2020 10:47 AM
To: AOStaffQuestions <AOStaffQuestions@epa.gov>
Cc: Carpenter, Wesley <Carpenter.Wesley@epa.gov>
Subject: RE: CDC recommendations to improve indoor ventilation?

Hi Wes – Following up on my previous question and your response, were you able to find out anything additional on the ventilation? I noticed this list of things that EPA is recommending to help protect against COVID-19, but EPA does not actually appear to be planning to do/allow for these things in the workplace as we reopen.

https://www.epa.gov/coronavirus/how-can-i-increase-ventilation-home-help-protect-my-family-covid-19

Thanks,
Elizabeth

From: AOStaffQuestions <AOStaffQuestions@epa.gov>
Sent: Tuesday, June 16, 2020 5:45 PM
To: Corona, Elizabeth <Corona.Elizabeth@epa.gov>
Cc: AOStaffQuestions <AOStaffQuestions@epa.gov>; Carpenter, Wesley <Carpenter.Wesley@epa.gov>
Subject: RE: CDC recommendations to improve indoor ventilation?

Elizabeth:

Good evening. Thanks for reaching out to me on the subject question. OMS is working with GSA and OAR regarding the ventilation of buildings. I am going to check with OMS to obtain more details and will follow-up.

Wes

From: Corona, Elizabeth <Corona.Elizabeth@epa.gov>
Sent: Thursday, June 04, 2020 1:29 PM
To: AOStaffQuestions <AOStaffQuestions@epa.gov>
Subject: CDC recommendations to improve indoor ventilation?

What, if anything, does the Agency plan to do regarding the CDC recommendations to improve ventilation in the building? https://www.cdc.gov/coronavirus/2019-ncov/community/office-buildings.html

I've pasted the text of the CDC recommendations below.

- Take steps to improve ventilation in the building:
  - Increase the percentage of outdoor air (e.g., using economizer modes of HVAC operations) potentially as high as 100% (first verify compatibility with HVAC system capabilities for both temperature and humidity control as well as compatibility with outdoor/indoor air quality considerations).
  - Increase total airflow supply to occupied spaces, if possible.
  - Disable demand-control ventilation (DCV) controls that reduce air supply based on temperature or occupancy.
  - Consider using natural ventilation (i.e., opening windows if possible and safe to do so) to increase outdoor air dilution of indoor air when environmental conditions and building requirements allow.
  - Improve central air filtration:
    - Increase air filtrationexternal icon to as high as possible (MERV 13 or 14) without significantly diminishing design airflow.
    - Inspect filter housing and racks to ensure appropriate filter fit and check for ways to minimize filter bypass
  - Consider running the building ventilation system even during unoccupied times to maximize dilution ventilation.
  - Generate clean-to-less-clean air movement pdf iconexternal iconby re-evaluating the positioning of supply and exhaust air diffusers and/or dampers and adjusting zone supply and exhaust flow rates to establish measurable pressure differentials. Have staff work in areas served by "clean" ventilation zones that do not include higher-risk areas such as visitor reception or exercise facilities (if open).
- Consider using portable high-efficiency particulate air (HEPA) fan/filtration systems to help enhance air cleaningpdf iconexternal icon (especially in higher risk areas).

- Ensure exhaust fans in restroom facilities are functional and operating at full capacity when the building is occupied.
- Consider using ultraviolet germicidal irradiation (UVGI)pdf iconexternal icon as a supplement to help inactivate the virus.

Message

From: HQ_Facilities_Updates [HQ_Facilities_Updates@epa.gov]
Sent: 6/22/2020 10:09:38 PM
To: All HQ Feds-nonFeds [All_HQ_Feds-nonFeds@epa.gov]
Subject: Phase 1 Begins Tuesday, June 23 – Office Operations

Tomorrow starts Phase 1 of our HQ Return to the Workplace Plan. The William Jefferson Clinton Buildings (North, South, East and West) and our offices in the Ronald Reagan Building and Potomac Yard Building will reopen. As a reminder, employees are encouraged to continue teleworking. If you choose to report to the workplace, here is what you should know:

Entering the Building

- Please self-screen by reviewing the self-assessment questionnaire, and do not enter the building if you answer yes to any of the listed questions.
- We have identified separate entry and exit areas in order to maintain and support social distancing.
    - EPA entry security screening locations will include: the main entrances of each of the four WJ Clinton buildings (North, South, East and West), RRB entrance on the side with turnstiles, and the main entrance of PY.
    - Exiting locations in the WJC Buildings will be as follows: West Employee entrance/exit (opposite RRB), East Employee entrance/exit (under the arch), the WJC North courtyard entrance/exit, and the Pennsylvania Avenue entrance/exit, and RRB on the opposite side from the turnstiles. The main entrance of PY will be marked with signage to create distinct entrance and exit areas. In the event of an emergency, all building exits will be open and accessible.
- For employees in FTC or RRB, the District of Columbia's Phase 2 guidance recommends that individuals should wear a cloth face covering when around other people who are not from your household. For those employees in PY, the Commonwealth of Virginia requires that people wear cloth face coverings when spending time in indoor public settings.

Enhanced Cleaning and Facility Operations and Maintenance

- Hand sanitizer, sanitizer wipes, and disinfectant sprays have been placed around the workplace.
- High touch surface areas will be cleaned daily, such as elevator buttons, doorknobs/handles, handrails, and light switches.
- The General Services Administration is working to ensure our buildings are properly maintained by following CDC's guidance on optimum engineering controls for the building ventilation systems.

- Employees should not congregate in areas including, but not limited to, entry and exit doors, lobbies and foyers, elevators, stairwells, corridors, restrooms, pantries, kitchen and break areas, photocopy, and printer areas.
- Signage is posted in high traffic areas like doorways, pantries, restrooms, stairwells, and elevators to serve as reminders for social distancing and markings on the floor are displayed in entrance and elevator lobbies. Signage and floor markings will be continuously evaluated and changed as needed.
- Only two people at a time are allowed in the elevators. Maximum occupancy posters are hung outside the doors.

Badge Office

- At EPA Headquarters, the following badge office operations and services will be provided by appointment only: issuance of badges for new employees, building access card issuances, PIN re-sets, damaged badge troubleshooting, key issuances and returns, badge returns for departing employees and off-boarding/employee separations.

The Agency will continue to adjust and update its guidance based on CDC recommendations as well as local guidance. We will provide you with more information as it becomes available. Below are some resources and helpful tips for employees:

HQ Return to the Workplace Plan
Self-Assessment Questionnaire
How to Protect Yourself & Others
COVID-19 intranet site
Travel Guidelines During the Phased Return to Workplaces

Message

From: Jackson, Yvette [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=471286FDB21245768617020D920C6BCA-YJACKSON]
Sent: 6/4/2020 3:28:42 PM
To: SeVera Wilson [Wilson.SeVera@epa.gov]; Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]
CC: Jefferson, Gayle (Jefferson.Gayle@epa.gov) [Jefferson.Gayle@epa.gov]; Daniels, Alva [daniels.alva@epa.gov]
Subject: FW: Facility Reopening Signs
Attachments: BuildingSignageForm - Region 4 Request.pdf

Region 4's request. Thanks

From: Eubanks, Kristy <Eubanks.Kristy@epa.gov>
Sent: Thursday, June 04, 2020 9:39 AM
To: Jackson, Yvette <Jackson.Yvette@epa.gov>
Cc: Tellis, Vickie <Tellis.Vickie@epa.gov>; Ashmeade, Iris <Ashmeade.Iris@epa.gov>; Fortson, Donald O. <Fortson.DonaldO@epa.gov>
Subject: RE: Facility Reopening Signs

Hi Yvette,

Thank you so much for allowing us the opportunity to order this signage. Please see Region 4's attached request. Note: This request is for all of Region 4's facilities. We will disseminate amongst our facilities. If you have any questions, please let us know. Thanks - Kristy

Kristy H. Eubanks
Acting Director
Mission Support Division
USEPA – Region 4
404-562-8039 (work)
Ex. 6 Personal Privacy (PP) (cell)

From: Jackson, Yvette <Jackson.Yvette@epa.gov>
Sent: Tuesday, June 2, 2020 5:24 PM
To: Regional Mission Support Division - Directors <Regional_Mission_Support_Division_Directors@epa.gov>
Cc: Grantham, Nancy <Grantham.Nancy@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>; Daniels, Alva <daniels.alva@epa.gov>; Gutro, Doug <Gutro.Doug@epa.gov>; Mears, Mary <Mears.Mary@epa.gov>; Nitsch, Chad <Nitsch.Chad@epa.gov>; Jenkins, Brandi <Jenkins.Brandi@epa.gov>; Kelley, Jeff <kelley.jeff@epa.gov>; McAtee, Jeffrey <McAtee.Jeffrey@epa.gov>; Carey, Curtis <Carey.Curtis@epa.gov>; Mutter, Andrew <mutter.andrew@epa.gov>; Alpern, Michael <Alpern.Michael@epa.gov>; Holsman, Marianne <Holsman.Marianne@epa.gov>
Subject: Facility Reopening Signs

Good Afternoon Colleagues,

As we plan or have begun to reopen our facilities, signage is an essential element of the reopening plan. Attached is a form and signs for welcoming employees back to the facility, encouraging social distancing, hand washing and elevator distancing. These signs can be used at EPA facilities nationwide. You can have the signs printed locally or complete the form and return it to me by noon, Thursday, June 4, 2020. We will have the signs printed and shipped to your location. Let me know if you have questions.

Regards,

Yvette

Message

From: Jackson, Yvette [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=471286FDB21245768617020D920C6BCA-YJACKSON]
Sent: 6/4/2020 12:23:08 PM
To: SeVera Wilson [Wilson.SeVera@epa.gov]; Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]
CC: Jefferson, Gayle (Jefferson.Gayle@epa.gov) [Jefferson.Gayle@epa.gov]; Daniels, Alva [daniels.alva@epa.gov]
Subject: FW: Facility Reopening Signs
Attachments: 1-BuildingSignageForm-fillable_6-2 R1.pdf

Region 1's request.

From: Ottariano, Michael <Ottariano.Michael@epa.gov>
Sent: Thursday, June 04, 2020 7:02 AM
To: Jackson, Yvette <Jackson.Yvette@epa.gov>
Cc: Johnson, Arthur <Johnson.Arthur@epa.gov>; Weeks, Frederick <Weeks.Fred@epa.gov>
Subject: RE: Facility Reopening Signs

Yvette,

Please see the attached order for Region 1. This request is for both our lab facility and our Regional office.

Thank you,

Mike Ottariano
Chief, Customer Service and Facilities Branch
USEPA Region 1 – New England
5 Post Office Square
Boston, MA 02109-3912
(617) 918-1190

From: Jackson, Yvette <Jackson.Yvette@epa.gov>
Sent: Tuesday, June 02, 2020 5:24 PM
To: Regional Mission Support Division - Directors <Regional_Mission_Support_Division_Directors@epa.gov>
Cc: Grantham, Nancy <Grantham.Nancy@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>; Daniels, Alva <daniels.alva@epa.gov>; Gutro, Doug <Gutro.Doug@epa.gov>; Mears, Mary <Mears.Mary@epa.gov>; Nitsch, Chad <Nitsch.Chad@epa.gov>; Jenkins, Brandi <Jenkins.Brandi@epa.gov>; Kelley, Jeff <kelley.jeff@epa.gov>; McAtee, Jeffrey <McAtee.Jeffrey@epa.gov>; Carey, Curtis <Carey.Curtis@epa.gov>; Mutter, Andrew <mutter.andrew@epa.gov>; Alpern, Michael <Alpern.Michael@epa.gov>; Holsman, Marianne <Holsman.Marianne@epa.gov>
Subject: Facility Reopening Signs

Good Afternoon Colleagues,

As we plan or have begun to reopen our facilities, signage is an essential element of the reopening plan. Attached is a form and signs for welcoming employees back to the facility, encouraging social distancing, hand washing and elevator distancing. These signs can be used at EPA facilities nationwide. You can have the signs printed locally or complete the form and return it to me by noon, Thursday, June 4, 2020. We will have the signs printed and shipped to your location. Let me know if you have questions.

Regards,
Yvette

Message

From: Hunt, Loretta [Hunt.Loretta@epa.gov]
Sent: 6/22/2020 5:54:18 PM
To: Kamen, Mara [kamen.mara@epa.gov]; Patterson, Nicole [Patterson.Nicole@epa.gov]; Hart, Debbi [Hart.Debbi@epa.gov]
Subject: RE: R5 - Phase 3
Attachments: RE: Telework

This concerns me:

Ex. 5 Deliberative Process (DP)

Loretta L. Hunt
Acting Deputy Division Director
Policy, Planning and Training Division
Office of Human Resources
U.S. EPA
Phone: (202) 564-6963
Email: hunt.loretta@epa.gov

From: Kamen, Mara <kamen.mara@epa.gov>
Sent: Monday, June 22, 2020 1:29 PM
To: Hunt, Loretta <Hunt.Loretta@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>
Subject: FW: R5 - Phase 3

Close hold please. For discussion at the 3 pm meeting.

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Monday, June 22, 2020 1:20 PM
To: Szaro, Deb <Szaro.Deb@epa.gov>; Newton, Cheryl <Newton.Cheryl@epa.gov>; Packard, Elise <Packard.Elise@epa.gov>; Shaw, Betsy <Shaw.Betsy@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>
Subject: FW: R5 - Phase 3

Hi – Here are Doug's thoughts.

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

From: Benevento, Douglas <benevento.douglas@epa.gov>
Sent: Monday, June 22, 2020 10:16 AM
To: Vizian, Donna <Vizian.Donna@epa.gov>
Subject: FW: R5 - Phase 3

See my attached notes for Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Thanks

From: Thiede, Kurt <thiede.kurt@epa.gov>
Sent: Monday, June 22, 2020 9:16 AM
To: Benevento, Douglas <benevento.douglas@epa.gov>
Subject: R5 - Phase 3

Doug –

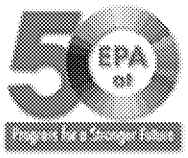
I really appreciate the weekly discussions you've been holding with RAs. Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Happy to discuss,
Kurt

Kurt A. Thiede
Regional Administrator
U.S. EPA Region 5
77 W Jackson Blvd
Chicago, IL 60604
(312) 886-3000
thiede.kurt@epa.gov



Message

From: Robertson, Mary [Robertson.Mary@epa.gov]
Sent: 7/16/2020 5:09:57 PM
To: Kamen, Mara [kamen.mara@epa.gov]; Hart, Debbi [Hart.Debbi@epa.gov]
Subject: RE: Incoming Correspondence - Suspense: 28 Jul
Attachments: COVID Reopening questions - OHR Final 7.16.20.docx

Thanks – I'll pass along to Marilyn.

From: Kamen, Mara <kamen.mara@epa.gov>
Sent: Thursday, July 16, 2020 12:57 PM
To: Robertson, Mary <Robertson.Mary@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>
Subject: RE: Incoming Correspondence - Suspense: 28 Jul

With my edits. Thanks.

From: Robertson, Mary <Robertson.Mary@epa.gov>
Sent: Thursday, July 16, 2020 11:58 AM
To: Kamen, Mara <kamen.mara@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>
Subject: RE: Incoming Correspondence - Suspense: 28 Jul

See attached for some edits. I tried to shorten response to 8.

From: Kamen, Mara <kamen.mara@epa.gov>
Sent: Thursday, July 16, 2020 11:47 AM
To: Robertson, Mary <Robertson.Mary@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>
Subject: RE: Incoming Correspondence - Suspense: 28 Jul

Not sure we need to combine. Loretta's already went to Marilyn. This needs a small bit of editing. Thanks.

From: Robertson, Mary <Robertson.Mary@epa.gov>
Sent: Thursday, July 16, 2020 11:43 AM
To: Kamen, Mara <kamen.mara@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>
Subject: RE: Incoming Correspondence - Suspense: 28 Jul

FYI - I'm consolidating Adam's responses with Loretta's and will send to you shortly.

From: Link, Adam (John) <link.john@epa.gov>
Sent: Thursday, July 16, 2020 11:38 AM
To: Kamen, Mara <kamen.mara@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>
Cc: Patterson, Nicole <Patterson.Nicole@epa.gov>; Robertson, Mary <Robertson.Mary@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>
Subject: RE: Incoming Correspondence - Suspense: 28 Jul

Good morning,

Please see LERD's drafted responses below.

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

J. Adam Link, OHR
(202) 564-6463; link.john@epa.gov

From: Kamen, Mara <kamen.mara@epa.gov>
Sent: Thursday, July 16, 2020 7:47 AM
To: Hunt, Loretta <Hunt.Loretta@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>
Cc: Link, Adam (John) <link.john@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Robertson, Mary <Robertson.Mary@epa.gov>
Subject: RE: Incoming Correspondence - Suspense: 28 Jul

Looks good. Just a minor edit: Ex. 5 Deliberative Process (DP) Thanks!

Ex. 5 Deliberative Process (DP)

From: Hunt, Loretta <Hunt.Loretta@epa.gov>
Sent: Wednesday, July 15, 2020 6:55 PM
To: Kamen, Mara <kamen.mara@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>
Cc: Link, Adam (John) <link.john@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>
Subject: RE: Incoming Correspondence - Suspense: 28 Jul

Draft responses below: Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Loretta L. Hunt, OHR
(202) 564-6963; hunt.loretta@epa.gov

From: Kamen, Mara <kamen.mara@epa.gov>
Sent: Tuesday, July 14, 2020 5:31 PM
To: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Link, Adam (John) <link.john@epa.gov>
Cc: Hart, Debbi <Hart.Debbi@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>
Subject: FW: Incoming Correspondence - Suspense: 28 Jul

Looping in Loretta and Adam for responses. Thanks.

From: Braxton, Marilyn <Braxton.Marilyn@epa.gov>
Sent: Tuesday, July 14, 2020 5:12 PM
To: Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Gantt, Melissa <Gantt.Melissa@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Robertson, Mary <Robertson.Mary@epa.gov>; Jackson, Yvette <Jackson.Yvette@epa.gov>; Daniels, Alva <daniels.alva@epa.gov>; Morina, Lenee <Morina.Lenee@epa.gov>; Patrick, Kimberly <Patrick.Kimberly@epa.gov>; Legare, Pamela <Legare.Pamela@epa.gov>; Macht, Jennifer <Macht.Jennifer@epa.gov>
Cc: Bell, Matthew <Bell.Matthew@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>; Saunders-Gadri, Linda <Saunders-Gadri.Linda@epa.gov>; Alston, Cynthia <Alston.Cynthia@epa.gov>
Subject: RE: Incoming Correspondence - Suspense: 28 Jul

Yes, I can work on a consolidated draft of this response. Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Sent: Tuesday, July 14, 2020 4:43 PM

To: Gantt, Melissa <Gantt.Melissa@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Robertson, Mary <Robertson.Mary@epa.gov>
Cc: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Bell, Matthew <Bell.Matthew@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>; Saunders-Gadri, Linda <Saunders-Gadri.Linda@epa.gov>; Alston, Cynthia <Alston.Cynthia@epa.gov>
Subject: RE: Incoming Correspondence - Suspense: 28 Jul

Marilyn – Can you coordinate the response? Some of these need to be answered by the IO. Let me know if you want to discuss.

Lynnann Hitchens
Acting Deputy Assistant Administrator for
Administration and Resources Management
Office of Mission Support
US EPA
P: 202-564-3184
M: Ex. 6 Personal Privacy (PP)

From: Gantt, Melissa <Gantt.Melissa@epa.gov>
Sent: Tuesday, July 14, 2020 3:14 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Robertson, Mary <Robertson.Mary@epa.gov>
Cc: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Bell, Matthew <Bell.Matthew@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>; Saunders-Gadri, Linda <Saunders-Gadri.Linda@epa.gov>; Alston, Cynthia <Alston.Cynthia@epa.gov>
Subject: Incoming Correspondence - Suspense: 28 Jul

Good Afternoon

Please see the attached incoming correspondence, AL-6055, Subject: EPA Reopening Letter, Suspense: 28 Jul. Thanks☺

Melissa Gantt
The Office of Mission Support
Immediate Office
U. S. Environmental Protection Agency
1200 Pennsylvania Ave., N.W.
Washington D.C. 20460
Mail Code 3101A
Gantt.melissa@epa.gov
https://www.epa.gov/
202-564-4600 (office)
Ex. 6 Personal Privacy (PP) (cell)

Message

From: Robertson, Mary [Robertson.Mary@epa.gov]
Sent: 7/16/2020 3:58:29 PM
To: Kamen, Mara [kamen.mara@epa.gov]; Hart, Debbi [Hart.Debbi@epa.gov]
Subject: RE: Incoming Correspondence - Suspense: 28 Jul
Attachments: COVID Reopening questions.docx

See attached for some edits. I tried to shorten response to 8.

From: Kamen, Mara <kamen.mara@epa.gov>
Sent: Thursday, July 16, 2020 11:47 AM
To: Robertson, Mary <Robertson.Mary@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>
Subject: RE: Incoming Correspondence - Suspense: 28 Jul

Not sure we need to combine. Loretta's already went to Marilyn. This needs a small bit of editing. Thanks.

From: Robertson, Mary <Robertson.Mary@epa.gov>
Sent: Thursday, July 16, 2020 11:43 AM
To: Kamen, Mara <kamen.mara@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>
Subject: RE: Incoming Correspondence - Suspense: 28 Jul

FYI - I'm consolidating Adam's responses with Loretta's and will send to you shortly.

From: Link, Adam (John) <link.john@epa.gov>
Sent: Thursday, July 16, 2020 11:38 AM
To: Kamen, Mara <kamen.mara@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>
Cc: Patterson, Nicole <Patterson.Nicole@epa.gov>; Robertson, Mary <Robertson.Mary@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>
Subject: RE: Incoming Correspondence - Suspense: 28 Jul

Good morning,

Please see LERD's drafted responses below.

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

J. Adam Link, OHR
(202) 564-6463; link.john@epa.gov

From: Kamen, Mara <kamen.mara@epa.gov>
Sent: Thursday, July 16, 2020 7:47 AM
To: Hunt, Loretta <Hunt.Loretta@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>
Cc: Link, Adam (John) <link.john@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Robertson, Mary <Robertson.Mary@epa.gov>
Subject: RE: Incoming Correspondence - Suspense: 28 Jul

Looks good. Just a minor edit: Ex. 5 Deliberative Process (DP) This can go to Marilyn Braxton. Thanks!

From: Hunt, Loretta <Hunt.Loretta@epa.gov>
Sent: Wednesday, July 15, 2020 6:55 PM
To: Kamen, Mara <kamen.mara@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>
Cc: Link, Adam (John) <link.john@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>
Subject: RE: Incoming Correspondence - Suspense: 28 Jul

Draft responses below. Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Loretta L. Hunt, OHR
(202) 564-6963; hunt.loretta@epa.gov

From: Kamen, Mara <kamen.mara@epa.gov>
Sent: Tuesday, July 14, 2020 5:31 PM
To: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Link, Adam (John) <link.john@epa.gov>

Cc: Hart, Debbi <Hart.Debbi@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>
Subject: FW: Incoming Correspondence - Suspense: 28 Jul

Looping in Loretta and Adam for responses. Thanks.

From: Braxton, Marilyn <Braxton.Marilyn@epa.gov>
Sent: Tuesday, July 14, 2020 5:12 PM
To: Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Gantt, Melissa <Gantt.Melissa@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Robertson, Mary <Robertson.Mary@epa.gov>; Jackson, Yvette <Jackson.Yvette@epa.gov>; Daniels, Alva <daniels.alva@epa.gov>; Morina, Lenee <Morina.Lenee@epa.gov>; Patrick, Kimberly <Patrick.Kimberly@epa.gov>; Legare, Pamela <Legare.Pamela@epa.gov>; Macht, Jennifer <Macht.Jennifer@epa.gov>
Cc: Bell, Matthew <Bell.Matthew@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>; Saunders-Gadri, Linda <Saunders-Gadri.Linda@epa.gov>; Alston, Cynthia <Alston.Cynthia@epa.gov>
Subject: RE: Incoming Correspondence - Suspense: 28 Jul

Ex. 5 Deliberative Process (DP)

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Sent: Tuesday, July 14, 2020 4:43 PM
To: Gantt, Melissa <Gantt.Melissa@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Robertson, Mary <Robertson.Mary@epa.gov>
Cc: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Bell, Matthew <Bell.Matthew@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>; Saunders-Gadri, Linda <Saunders-Gadri.Linda@epa.gov>; Alston, Cynthia <Alston.Cynthia@epa.gov>
Subject: RE: Incoming Correspondence - Suspense: 28 Jul

Marilyn – Can you coordinate the response? Some of these need to be answered by the IO. Let me know if you want to discuss.

Lynnann Hitchens
Acting Deputy Assistant Administrator for
Administration and Resources Management

Office of Mission Support
US EPA
P: 202-564-3184
M: Ex. 6 Personal Privacy (PP)

From: Gantt, Melissa <Gantt.Melissa@epa.gov>
Sent: Tuesday, July 14, 2020 3:14 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Robertson, Mary <Robertson.Mary@epa.gov>
Cc: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Bell, Matthew <Bell.Matthew@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>; Saunders-Gadri, Linda <Saunders-Gadri.Linda@epa.gov>; Alston, Cynthia <Alston.Cynthia@epa.gov>
Subject: Incoming Correspondence - Suspense: 28 Jul

Good Afternoon

Please see the attached incoming correspondence, AL-6055, Subject: EPA Reopening Letter, Suspense: 28 Jul. Thanks☺

Melissa Gantt
The Office of Mission Support
Immediate Office
U. S. Environmental Protection Agency
1200 Pennsylvania Ave., N.W.
Washington D.C. 20460
Mail Code 3101A
Gantt.melissa@epa.gov
https://www.epa.gov/
202-564-4600 (office)
Ex. 6 Personal Privacy (PP) (cell)

Message

From: Ridings, Sharon [Ridings.Sharon@epa.gov]
Sent: 6/1/2020 1:23:00 PM
To: Kamen, Mara [kamen.mara@epa.gov]
CC: Hunt, Loretta [Hunt.Loretta@epa.gov]; Engebretson, Lizabeth [Engebretson.Lizabeth@epa.gov]
Subject: RE: Covid trainings
Attachments: DRAFT_COVID19TrainingOutline_DAM 052820.docx

Good morning again…

This document just landed in my email box! Daniel provided a nice outline for us to consider.

As for the slides, I sent a message to you this morning indicating that our meeting on Friday was cancelled as Lynnann wishes to discuss the project with you and I before moving forward.

Sharon

Sharon L. Ridings
Chief Learning Officer
Training Branch / Policy Planning and Training Division
US Environmental Protection Agency
1201 Constitution Avenue
EPA East 1136, MC-3601M
Washington, DC 20460
202-564-7584
Ridings.Sharon@epa.gov

From: Kamen, Mara <kamen.mara@epa.gov>
Sent: Monday, June 1, 2020 9:21 AM
To: Ridings, Sharon <Ridings.Sharon@epa.gov>
Cc: Hunt, Loretta <Hunt.Loretta@epa.gov>; Engebretson, Lizabeth <Engebretson.Lizabeth@epa.gov>
Subject: RE: Covid trainings

Super! Thanks. What is the status of the reopening slides?

From: Ridings, Sharon <Ridings.Sharon@epa.gov>
Sent: Monday, June 1, 2020 9:18 AM
To: Kamen, Mara <kamen.mara@epa.gov>
Cc: Hunt, Loretta <Hunt.Loretta@epa.gov>; Engebretson, Lizabeth <Engebretson.Lizabeth@epa.gov>
Subject: RE: Covid trainings

Good morning ladies,

Daniel is preparing a document to outline his thoughts and experience from being on the frontline of the COVID virus. I sent a message to him and asked when we might receive the document and will let you know as soon as I hear back from him.

Sharon

Sharon L. Ridings
Chief Learning Officer
Training Branch / Policy Planning and Training Division
US Environmental Protection Agency
1201 Constitution Avenue
EPA East 1136, MC-3601M
Washington, DC 20460
202-564-7584
Ridings.Sharon@epa.gov

From: Kamen, Mara <kamen.mara@epa.gov>
Sent: Friday, May 29, 2020 5:15 PM
To: Ridings, Sharon <Ridings.Sharon@epa.gov>
Cc: Hunt, Loretta <Hunt.Loretta@epa.gov>; Engebretson, Lizabeth <Engebretson.Lizabeth@epa.gov>
Subject: Covid trainings

Sharon,

Please let me know when you are ready to preview the Public Health Officer briefing or the reopening trainings for the OHR leadership team. Thanks.

If you have questions or need further information, please feel free to contact me.

Mara

Mara J. Kamen
Director, Office of Human Resources
Office of Mission Support
US Environmental Protection Agency
1200 Pennsylvania Ave. NW
Washington DC 20460
202.564.4606
kamen.mara@epa.gov

Message

From: Kamen, Mara [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=A9B3C08993BF4280A3A84F0743C7E427-KAMEN, MARA]
Sent: 6/24/2020 7:40:44 PM
To: Hart, Debbi [Hart.Debbi@epa.gov]
Subject: RE: Draft Phase 3 Options

That was from Lynnann. Ex. 5 Deliberative Process (DP)

From: Hart, Debbi <Hart.Debbi@epa.gov>
Sent: Wednesday, June 24, 2020 2:47 PM
To: Kamen, Mara <kamen.mara@epa.gov>
Subject: RE: Draft Phase 3 Options

Forgot to say Ex. 5 Deliberative Process (DP)

From: Kamen, Mara
Sent: Wednesday, June 24, 2020 11:00 AM
To: Hart, Debbi <Hart.Debbi@epa.gov>
Subject: RE: Draft Phase 3 Options

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

From: Hart, Debbi <Hart.Debbi@epa.gov>
Sent: Wednesday, June 24, 2020 10:57 AM
To: Kamen, Mara <kamen.mara@epa.gov>
Subject: RE: Draft Phase 3 Options

Ex. 5 Deliberative Process (DP)

From: Kamen, Mara
Sent: Wednesday, June 24, 2020 10:46 AM
To: Newton, Cheryl <Newton.Cheryl@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>; Shaw, Betsy <Shaw.Betsy@epa.gov>; Szaro, Deb <Szaro.Deb@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Packard, Elise <Packard.Elise@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Castro, Denise <Castro.Denise@epa.gov>
Subject: RE: Draft Phase 3 Options

I tried to clarify these points in the last version. Thanks.

From: Newton, Cheryl <Newton.Cheryl@epa.gov>
Sent: Wednesday, June 24, 2020 9:58 AM
To: Hunt, Loretta <Hunt.Loretta@epa.gov>; Shaw, Betsy <Shaw.Betsy@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Szaro, Deb <Szaro.Deb@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Packard, Elise <Packard.Elise@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Castro, Denise <Castro.Denise@epa.gov>
Subject: RE: Draft Phase 3 Options

Thanks Loretta!

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Thanks!

From: Hunt, Loretta <Hunt.Loretta@epa.gov>
Sent: Wednesday, June 24, 2020 8:25 AM
To: Shaw, Betsy <Shaw.Betsy@epa.gov>; Newton, Cheryl <Newton.Cheryl@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Szaro, Deb <Szaro.Deb@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Packard, Elise <Packard.Elise@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Castro, Denise <Castro.Denise@epa.gov>
Subject: RE: Draft Phase 3 Options

Everyone,

Ex. 5 Deliberative Process (DP)

Loretta L. Hunt
Acting Deputy Division Director
Policy, Planning and Training Division
Office of Human Resources
U.S. EPA
Phone: (202) 564-6963
Email: hunt.loretta@epa.gov

From: Shaw, Betsy <Shaw.Betsy@epa.gov>
Sent: Wednesday, June 24, 2020 8:57 AM
To: Newton, Cheryl <Newton.Cheryl@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Szaro, Deb <Szaro.Deb@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Packard, Elise <Packard.Elise@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Castro, Denise <Castro.Denise@epa.gov>
Subject: RE: Draft Phase 3 Options

Morning all,

Ex. 5 Deliberative Process (DP)

Thanks,

Betsy

From: Newton, Cheryl <Newton.Cheryl@epa.gov>
Sent: Wednesday, June 24, 2020 8:42 AM
To: Kamen, Mara <kamen.mara@epa.gov>; Szaro, Deb <Szaro.Deb@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Packard, Elise <Packard.Elise@epa.gov>; Shaw, Betsy <Shaw.Betsy@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Castro, Denise <Castro.Denise@epa.gov>
Subject: RE: Draft Phase 3 Options

Here's my version. It builds on Lynnann' s and Elise's, and I think I pulled in Deb's in adding mine. Thanks!

From: Kamen, Mara <kamen.mara@epa.gov>
Sent: Wednesday, June 24, 2020 7:35 AM
To: Szaro, Deb <Szaro.Deb@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Packard, Elise <Packard.Elise@epa.gov>; Newton, Cheryl <Newton.Cheryl@epa.gov>; Shaw, Betsy <Shaw.Betsy@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Castro, Denise <Castro.Denise@epa.gov>
Subject: RE: Draft Phase 3 Options

I'll add my comments on next. Thanks.

From: Szaro, Deb <Szaro.Deb@epa.gov>
Sent: Wednesday, June 24, 2020 7:58 AM
To: Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Packard, Elise <Packard.Elise@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Newton, Cheryl <Newton.Cheryl@epa.gov>; Shaw, Betsy <Shaw.Betsy@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Castro, Denise <Castro.Denise@epa.gov>
Subject: RE: Draft Phase 3 Options

My edits added.

From: Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Sent: Tuesday, June 23, 2020 6:29 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Packard, Elise <Packard.Elise@epa.gov>; Szaro, Deb <Szaro.Deb@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Newton, Cheryl <Newton.Cheryl@epa.gov>; Shaw, Betsy <Shaw.Betsy@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Castro, Denise <Castro.Denise@epa.gov>
Subject: RE: Draft Phase 3 Options

Some comments

Lynnann Hitchens
Acting Deputy Assistant Administrator for
Administration and Resources Management
Office of Mission Support
US EPA
P: 202-564-3184
M: Ex. 6 Personal Privacy (PP)

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Tuesday, June 23, 2020 5:46 PM
To: Packard, Elise <Packard.Elise@epa.gov>; Szaro, Deb <Szaro.Deb@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Newton, Cheryl <Newton.Cheryl@epa.gov>; Shaw, Betsy <Shaw.Betsy@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Castro, Denise <Castro.Denise@epa.gov>
Subject: RE: Draft Phase 3 Options

Hi Everyone,

Attached is the revised version based on the conversation this afternoon. Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

From: Packard, Elise <Packard.Elise@epa.gov>
Sent: Tuesday, June 23, 2020 8:37 AM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Szaro, Deb <Szaro.Deb@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Newton, Cheryl <Newton.Cheryl@epa.gov>; Shaw, Betsy <Shaw.Betsy@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Castro, Denise <Castro.Denise@epa.gov>
Subject: RE: Draft Phase 3 Options

Some thoughts! Thanks so much.

Elise B. Packard
Deputy General Counsel for Operations
U.S. EPA Office of General Counsel, Rm. 4020A
(202) 564-7729

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Monday, June 22, 2020 6:44 PM
To: Szaro, Deb <Szaro.Deb@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Newton, Cheryl <Newton.Cheryl@epa.gov>; Shaw, Betsy <Shaw.Betsy@epa.gov>; Packard, Elise <Packard.Elise@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Castro, Denise <Castro.Denise@epa.gov>
Subject: Draft Phase 3 Options

Thanks everyone for the discussion today. I tried to capture our discussion in the attached. Melissa is finding a tine for us to talk tomorrow.

Message

From: Kamen, Mara [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=A9B3C08993BF4280A3A84F0743C7E427-KAMEN, MARA]
Sent: 6/23/2020 9:54:23 PM
To: Loretta Hunt [Hunt.Loretta@epa.gov]; Hart, Debbi [hart.debbi@epa.gov]; Patterson, Nicole [Patterson.Nicole@epa.gov]
Subject: EPA Reconstitution Slides 6.22.2020.pptx
Attachments: EPA Reconstitution Slides 6.22.2020.pptx

Attached please find the finalized slides for the Returning to the Workplace overview. I have incorporated Lynnann's comments to address the fluidity of Phase 3.

Ex. 5 Deliberative Process (DP)

Message

From: Kamen, Mara [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=A9B3C08993BF4280A3A84F0743C7E427-KAMEN, MARA]
Sent: 6/8/2020 4:24:03 PM
To: Hart, Debbi [Hart.Debbi@epa.gov]
Subject: RE: Please take a look when you have a minute--draft COVID group write-up--

Edits below. Thanks for doing this. I added a paragraph to outline more of the work conducted and a final paragraph for what this meant for the team. If it is over the top, feel free to scale back.

From: Hart, Debbi <Hart.Debbi@epa.gov>
Sent: Monday, June 8, 2020 11:29 AM
To: Kamen, Mara <kamen.mara@epa.gov>
Subject: RE: Please take a look when you have a minute--draft COVID group write-up--

Here's a start. Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

From: Kamen, Mara
Sent: Monday, June 08, 2020 10:33 AM
To: Hart, Debbi <Hart.Debbi@epa.gov>
Subject: RE: Please take a look when you have a minute--

Awesome! Thanks!

From: Hart, Debbi <Hart.Debbi@epa.gov>
Sent: Monday, June 8, 2020 10:25 AM
To: Kamen, Mara <kamen.mara@epa.gov>
Subject: RE: Please take a look when you have a minute--

Ex. 5 Deliberative Process (DP)

From: Kamen, Mara
Sent: Monday, June 08, 2020 10:19 AM
To: Hart, Debbi <Hart.Debbi@epa.gov>
Subject: RE: Please take a look when you have a minute--

Ex. 5 Deliberative Process (DP)

From: Hart, Debbi <Hart.Debbi@epa.gov>
Sent: Monday, June 8, 2020 10:17 AM
To: Kamen, Mara <kamen.mara@epa.gov>
Subject: Please take a look when you have a minute--

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

Debbi Hart
Acting Deputy Director
Office of Human Resources
USEPA
202.564.2011
hart.debbi@epa.gov

****

Appointment

From: Christian, Megan [Christian.Megan@epa.gov]
Sent: 5/20/2020 2:15:48 PM
To: Leadership_Regional_Administrators [Leadership_Regional_Administrators@epa.gov]; Regional_Chiefs_of_Staff [Regional_Chiefs_of_Staff@epa.gov]; Leadership_Assistant_Administrators [Leadership_Assistant_Administrators@epa.gov]; Cascio, Wayne [Cascio.Wayne@epa.gov]; Baxter, Lisa [Baxter.Lisa@epa.gov]; Mehaffey, Megan [Mehaffey.Megan@epa.gov]; Baynes, Jeremy [baynes.jeremy@epa.gov]
CC: Robbins, Chris [Robbins.Chris@epa.gov]

Subject: RA Call
Location: Microsoft Teams Meeting

Start: 5/22/2020 5:30:00 PM
End: 5/22/2020 6:30:00 PM
Show Time As: Tentative

Demonstration of ORD Modeling Tool of Gating Criteria

Note: Assistant Administrators are invited to attend.

Join Microsoft Teams Meeting

Ex. 6 Personal Privacy (PP) United States, Washington DC (Toll)

Conference ID: Ex. 6 Personal Privacy (PP)

Local numbers | Reset PIN | Learn more about Teams | Meeting options

---